

AUTHORIZATION: "GENERAL" USE & DISCLOSURE OF PHI

Please the appropriate facility:

- | | | |
|--|--|--|
| <input type="checkbox"/> Kennestone Hospital | <input type="checkbox"/> Cobb Hospital | <input type="checkbox"/> Physician's Group: _____ |
| <input type="checkbox"/> Windy Hill Hospital | <input type="checkbox"/> Paulding Hospital | <input type="checkbox"/> Douglas Hospital _____ (Name of Practice) |
| <input type="checkbox"/> Homecare | <input type="checkbox"/> Hospice | <input type="checkbox"/> Other: _____ |

Please complete the following section (print clearly)

Patient's Last Name, First Name, MI Birth Date (Month/Day/Year)

Street Address/Apt # (Include Complete Mailing Address) Medical Record #: / Social Security #: (Optional)

City State Zip Home Phone #: Alternate Phone #:

RELEASE INFORMATION TO (Recipient of Use/Disclosure):

Name of Person or Organization Receiving Information Telephone #:

Street Address (Include Complete Mailing Address) Suite # / Apt. # / PO #:

City State Zip

PERSON(S)/ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE: _____

REQUESTED DATE(S): From _____ To _____

Other Dates (if applicable): _____

SPECIFIC DESCRIPTION OF PHI TO BE USED/DISCLOSED:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Radiology Report(s) | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Summary/Abstract |
| <input type="checkbox"/> Complete Billing Record | <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> All Diagnostic Reports | <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> History & Physical | |
| <input type="checkbox"/> Other, please specify: _____ | | | |

SPECIFIC PURPOSE OF PHI DISCLOSURE REQUEST:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Patient/Individual Request (For Non-Patient Use) | <input type="checkbox"/> Referral/Second Opinion | <input type="checkbox"/> School/Immunization Record | <input type="checkbox"/> Disability Benefits |
| <input type="checkbox"/> Requested by WellStar Health System | <input type="checkbox"/> Insurance/Eligibility Benefits | <input type="checkbox"/> Marketing/Fundraising | <input type="checkbox"/> Attorney/Legal Proceedings |
| <input type="checkbox"/> Other, please specify: _____ | | | |

I understand that Protected Health Information (PHI) used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law. I understand that I have a right to revoke this authorization at any time and that my revocation must be submitted in writing to the WellStar facility where I received care. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that WellStar may receive compensation from a third party if the specific purpose of this authorization is for Marketing related activities. I understand that WellStar cannot require me to sign this Authorization as a condition to treatment unless the provision of healthcare by WellStar is solely for the purpose of creating protected health information for disclosure to a third party. I understand that I will be given a copy of this authorization upon my signature.

DATE/SIGNATURE:

_____ Date Authorization Signed By Patient (or) Legal Guardian/Authorized Personal Representative

Print Patient Name (or) Print Name of Legal Guardian/Authorized Personal Representative

Signature of Patient (or) Signature of Legal Guardian/Authorized Personal Representative*

* Please indicate your relationship to the patient

EXPIRATION DATE: This authorization will expire on [indicate specific date or event]:

(NOTE: If a date or event is not indicated (left blank), this authorization shall automatically expire (90) days from the original date authorization signed by patient)