WELLSTAR Health System

AUTHORIZATION: "GENERAL" USE & DISCLOSURE OF PHI

Please ☑ the appropriate facility:

- ☐ Kennestone Hospital
- ☐ Windy Hill Hospital
- ☐ Homecare
- ☐ Cobb Hospital
- ☐ Paulding Hospital
- ☐ Hospice
- ☐ Physician's Group: _____ *(Name of Practice)*
- ☐ Douglas Hospital
- ☐ 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:

- ☐ Complete Medical Record
- ☐ Complete Billing Record
- ☐ All Diagnostic Reports
- ☐ Radiology Report(s)
- ☐ Laboratory Report(s)
- ☐ Pathology Report(s)
- ☐ Discharge Summary
- ☐ Consultation Report(s)
- ☐ History & Physical
- ☐ Summary/Abstract
- ☐ Progress Notes
- ☐ Other, *please specify:* _____

SPECIFIC PURPOSE OF PHI DISCLOSURE REQUEST:

- ☐ Patient/Individual Request *(For Non-Patient Use)*
- ☐ Requested by WellStar Health System
- ☐ Referral/Second Opinion
- ☐ Insurance/Eligibility Benefits
- ☐ School/Immunization Record
- ☐ Marketing/Fundraising
- ☐ Disability Benefits
- ☐ Attorney/Legal Proceedings
- ☐ 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

_____ *(or)* _____

Print Patient Name — **Print Name of Legal Guardian/Authorized Personal Representative**

_____ *(or)* _____

Signature of Patient — **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)