Wellstar Health System

For Internal Purposes
Account Number: _____
Medical Record Number: _____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name, if applicable: _____ Last 4 digits of Social Security #: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Home / Cell Phone: _____ Work Phone: _____

Email address: _____

1. WELLSTAR HEALTH SYSTEM:
   I authorize representatives from the following facility / facilities to disclose the above-named individual's health information as directed below (check one or more):

   ❒ Atlanta Medical Center Downtown (closed 11/1/22) ❒ Kennestone Regional Medical Center ❒ Sylvan Grove Hospital
   ❒ Atlanta Medical Center South (closed 11/1/22) ❒ North Fulton Hospital ❒ West Georgia Medical Center
   ❒ Cobb Hospital ❒ Paulding Hospital ❒ Windy Hill Hospital
   ❒ Douglas Hospital ❒ Spalding Regional Hospital ❒ All Locations
   ❒ Wellstar Medical Group - Practice Name: _____ Practice Location: _____
   ❒ Other Wellstar facility (specify name of facility): _____

2. TO WHOM MY HEALTH INFORMATION MAYBE DISCLOSED:

   I authorize that the health information described below in this form may be disclosed to the following entity(ies) / individual(s) (please include the name, address, and any other information necessary to identify the person or class of persons to whom to send the requested information in the method specified below in Section 3):

   (check any box that applies)

   ❒ To me at the address listed above

   ❒ To someone else, or to me at an address different from what is listed above (fill in all information below if this box is checked)

   Name: _____

   Street Address: _____

   City, State, ZIP: _____

   Fax / Telephone: _____

   Email Address: _____

3. RELEASE INSTRUCTIONS:

   ❒ Please send my record via MyChart (at no cost).
   You must have an active MyChart account. If you don't have an active account, go to this website to activate: mychart.wellstar.org and click on Sign Up (I don't have a code). You may call the MyChart support desk at 470-644-0419 with any questions.

   Records are available in MyChart if you were seen at these locations or the affiliated Wellstar Medical Group practices:
   -- From December 2013 to present at Kennestone Regional Medical Center
   -- From April 2014 to present at these hospitals: Cobb, Douglas, Paulding and Windy Hill
   -- From March 2018 to present at these hospitals: Atlanta Medical Center Downtown and South, North Fulton, Spalding, Sylvan Grove and West Georgia

❒ Please send my record via eDelivery. You will receive an email with instructions on how to access your records.
❒ Please fax my health information to my healthcare provider. Faxing is restricted to continuity of care requests only.
❒ I would like to pick up my health information in person. If someone other than yourself will be picking it up, please provide their name: _____
❒ Please mail my health information to the address identified in Section 2 of this form.
❒ Other [please identify below the specific manner (form / format / method) in which you desire health information to be transmitted]:

_____

_____

_____

4. PURPOSE OF DISCLOSURE:

❒ Personal Use ❒ Insurance ❒ Disability
❒ Attorney / Legal ❒ Continuity of Care
❒ Other (please identify purpose of disclosure below):

_____

_____

_____

5. DESCRIPTION OF HEALTH INFORMATION TO BE INCLUDED:

Information	Dates of Service	Information	Dates of Service
❒ Office Notes	_____	❒ History and Physical	_____
❒ Operative Report	_____	❒ Consultations	_____
❒ Pathology Report	_____	❒ Discharge Summary	_____
❒ Cardiology / EKG Reports	_____	❒ Lab Results	_____
❒ Emergency Room Record	_____	❒ Radiology Report only	_____
❒ Billing Records	_____	❒ Radiology Images on a CD	_____
❒ Abstract Clinical Medical Records*	_____		
❒ Complete Clinical Medical Records	_____		
❒ Designated Record Set**	_____		

*Abstract of my health information (information needed for continuity of care includes physician notes, emergency room records, test results, and radiology reports)
**Designated Record Set includes but is not limited to clinical and financial records

6. EXPIRATION OF AUTHORIZATION:
Unless I request in writing otherwise, this authorization will expire one year after signature of this form.

7. RIGHT TO REVOKE AUTHORIZATION:
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation via email to ROI_EPIC@wellstar.org, or via mail attn. HIM - Release of Information, 1800 Parkway Place, Marietta, GA 30067. I understand that the revocation will not apply to any health information that has already been released in response to this authorization. I also understand that a revocation is not effective with respect to actions Wellstar has taken in reliance on a previous authorization, or where the authorization was obtained as a condition of obtaining insurance coverage and applicable law provides the insurer with the right to contest a claim under the policy or the policy itself.

8 FEES:
I understand that federal and state laws allow for certain reasonable, cost-based fees to be charged for the copying and provision of patient records. If any such fees are applicable to my request, I will be responsible for their payment.

9. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE:
I understand that authorizing the use or disclosure of the information above is voluntary. I understand that Wellstar may not condition my treatment, payment for health care, and/or enrollment or eligibility for benefits upon my signing of this authorization, except in limited circumstances. Specifically, I understand that Wellstar Health System may decline to treat me if I refuse to sign this form in the following instances: (1) if I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a pre-employment drug screen).

10. RE-DISCLOSURE:
I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations unless such federal privacy regulations specify otherwise.

11. RELEASE AND WAIVER:
I release Wellstar Health System, each of the Wellstar Health System facilities checked or otherwise identified above and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me.

12. SENSITIVE HEALTH INFORMATION:
If the health information that I have requested Wellstar Health System to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Compex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis (collectively "Sensitive Health Information"), I authorize the disclosure of such Sensitive Health Information and waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above.

I indicate my agreement to this Section 12 by initialing here: _____

13. COMPLIANCE WITH THE LAW:
Wellstar strictly adheres to applicable law and its patients' privacy preferences to safeguard the privacy and security of heath information. Records provided pursuant to a request will not include information that is prohibited from disclosure pursuant to identified privacy preferences and/or applicable federal and state law, including but not limited to HIPAA and the 21st Century Cures Act. Depending on the circumstances, information provided may also not include certain information that poses a risk to patients and/or others, in accordance with applicable law and ethical standards.

_____	_____	_____
Signature of Patient (or Patient's Legal Representative)	Date	Time

_____
Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.