WELLSTAR
North Fulton Hospital

NFRRF

North Fulton Hospital, Health Information Management 3000 Hospital Blvd., Roswell, GA 30076 (770) 751-2679	Medical Record # _____ Account # _____ Pick up: _____ Mail Out: _____ Fax: _____

Authorization for Release of Confidential Medical Information – Patient Form

Medical services provided by North Fulton Hospital are not condition upon this authorization

Patient Name: _____ S.S.# _____

Date of Birth: _____ Patient Phone Number _____

Treatment dates to be released _____

Type of Visit Inpatient ___ Out Patient Surgery ___ ER ___ Out Patient Test ___ Therapy ___ Other _____

This information is to be: _____ ***Released to*** _____ ***Obtained from***

Name _____ Attn: _____

Address _____

City, State, Zip _____

Phone# _____

Purpose of the Disclosure (check one)

___ Insurance ___ Personal

___ Legal ___ Continuing Care

___ Other Specify _____

Fax Number: _____ *Records will be faxed for urgent medical care only*

The information disclosed may be subject to re-disclosure by the recipient and will no longer be protected by Privacy Protection Rules

Portions of Record needed - Check applicable sections:

___ Face Sheet
___ Discharge Summary
___ History & Physical
___ Consultations
___ Operative Report
___ Pathology Reports
___ ER Record
___ Therapy Records
___ Radiology/Imaging Report/s
___ EKG/Echo/Cardiology
___ Lab Reports
___ Other _____
___ Physician's Progress Notes
___ Drugs/Alcohol Test Results
___ HIV Testing/Information
___ Abstract of Record/s
___ Entire Record/s

Radiology films and billing must be requested and picked up from the specific department.

I hereby authorize North Fulton Hospital and/or Infocopy to disclose/or obtain medical records and/or other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable for Legal, Insurance, and/or Personal Use. I hereby release North Fulton Hospital and/or Infocopy from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intentions. Unless withdrawn, this consent will expire 90 days from the date signed.

____ This information may include Medical/Surgical, Psychiatric, Substance Abuse, and HIV/AIDS information.

____ I authorize that this information may be faxed to the requesting Health Care Provider.

Patient's Signature: _____ **Date**: _____

Patient's Representative: _____ **Date**: _____

Authority to sign on behalf of the patient is authorized by: _____

Witnessed by: _____

(Picture ID or the patient's signatures were used to verify identity)

Patient Label Here