



For Internal Purposes

Account Number: _____

Medical Record Number: _____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security Number (last 4 digits only): _____

Previous Name, if applicable: _____

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

Date of Birth: _____ Home Phone: _____ Work Phone: _____

1. WELLSTAR HEALTH SYSTEM FACILITY / FACILITIES

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
 - Atlanta Medical Center South
 - Cobb Hospital
 - Douglas Hospital
 - North Fulton Hospital
 - Kennestone Hospital
 - Paulding Hospital
 - Spalding Regional Hospital
 - Sylvan Grove Hospital
 - West Georgia Medical Center
 - Windy Hill Hospital
 - WellStar Medical Group
 - Other: _____
- Name(s) of provider(s): _____

2. RECEIVING PARTY

Please send my health information to:

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Fax Number (healthcare provider only): _____

I would like to pick up my medical records in person

I authorize _____ to pick up my medical records in person.
(Name of person authorized to receive the record)

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED

Complete medical record *(please specify dates of service)* _____

OR

Partial medical record *(please specify records below)*

<u>Information</u>	<u>Dates</u>	<u>Information</u>	<u>Dates</u>
<input type="checkbox"/> History and Physical	_____	<input type="checkbox"/> Office Notes	_____
<input type="checkbox"/> Consultations	_____	<input type="checkbox"/> Operative Reports	_____
<input type="checkbox"/> Discharge Summary	_____	<input type="checkbox"/> Pathology Reports	_____
<input type="checkbox"/> Lab Results	_____	<input type="checkbox"/> EKG Reports	_____
<input type="checkbox"/> X-rays	_____	<input type="checkbox"/> HIV / AIDS Information	_____
<input type="checkbox"/> Drug / Alcohol Abuse treatment	_____	<input type="checkbox"/> Mental Health Treatment	_____

Other: _____ - please specify dates of service: _____

You must check this box if you are also requesting Billing Records



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4. PURPOSE OF DISCLOSURE

- My personal records Attorney Disability
 Other: _____

5. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, this authorization will expire on _____. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which it was signed.
(insert date or event)

6. 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 present written revocation to the Health Information Management Department(s) of the WellStar Health System facility or facilities checked above. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee schedule may be viewed at www.wellstar.org.

8. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment. However, if I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that WellStar Health System may decline to treat me if I refuse to sign this information only if: (1) 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).

9. 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.

10. RELEASE AND WAIVER

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 Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above.

I also release WellStar Health System, each of the WellStar Health System facilities checked 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 above.

Signature of Patient (or Patient's Legal Representative)

Date

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.