AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

❑ **Midtown Medical Center** ❑ **Columbus Regional Medical Group** ❑ **Northside Medical Center** ❑ **John B. Amos Cancer Center**

Health Information Management Department
(706)571-1709 Office (706)571-1080 Fax

Patient Name:	Date of Birth:	Social Security Number (last 4 digits):
Address:	Telephone #: ❑ Home ❑ Cell	
City:	State:	Zip:

I hereby request and authorize *(print name of hospital/office/urgent care/physician):* _____
*(initial **one** or **more** choices below to the left as desired)*

_____ To **provide** my record(s) as checked below: (print *person's name)* _____ By:
(initial)
- ❑ PAPER in person ❑ Paper by mail: Address _____
- ❑ Fax # for physician/healthcare provider ONLY: _____ Phone # to confirm Fax #: _____
- ❑ Encrypted/Secured CD ROM
- ❑ Email (email address:_____) * email is HIGHLY DISCOURAGED due to the lack of security against hackers and/or accidental or unintended disclosure AND record size may prohibit our ability to send by email.

_____ Permit (print person's name) _____ to **review** my records as checked below.
(initial)
(NOTE: a record review requires an appointment which is scheduled by the HIM Dept)

_____ Permit (print person's name) _____ to **be present** during my: ❑ Consultation ❑ Exam ❑ Procedure/Surgery
(initial)
(please check appropriate box above)

_____ Use/disclose my PHI as described: _____
(initial)

This authorization applies to records or PHI access from the following date or dates of service: _____

Purpose of Use of Disclosure: ❑ At the request of the individual (patient) ❑ Medical/Treatment Purposes ❑ Legal/Litigation Purposes
❑ Social Security Disability Application ❑ Other: _____

DESCRIPTION OF INFORMATION TO BE RELEASED.

❑ Psychotherapy notes - Federal law requires a separate authorization to use or release psychotherapy notes.
↑ If you check this box, you may not check another box below

- ❑ Entire Medical Record
- ❑ Abstract of Record*
- ❑ Emergency Room Record
- ❑ Cardiac Cath Report/CD
- ❑ Pathology Slides/Blocks
- ❑ Radiology Films/CD
- ❑ Financial Record
- ❑ Other - Specify: _____

*An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

SPECIAL AUTHORIZATION (IF APPLICABLE)

If you authorizing the above entity to release information related to the testing, diagnosis, and treatment for any of the following conditions, sign your initials in front of the section which describes the type of information to be released.

Patient	Patient or Guardian	
(initial)	*(initial)*	My evaluation, testing, diagnosis, and treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on this authorization.
(initial)	*(initial)*	My evaluation, testing, diagnosis, and treatment concerning my mental health/rehabilitation information may be release to the recipient noted on this authorization.
(initial)	*(initial)*	My testing, diagnosis, and treatment for HIV/AIDS may be release to the recipient noted on this authorization.
(initial)	*(initial)*	All records, findings and results of any genetic test.

AUTHORIZATION SIGNATURE

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from Health Information Management. The completed revocation must be presented to Health Information Management. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. A Columbus Regional Health provider shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here:**
Date:_____ Event:_____

Patient's or Legal Representative's Signature	**Please Print Name**	**Today's Date**	**Time**

As Legal Representative, my relationship to the patient is_____. Any document proving such authority must be attached. The patient is unable to sign because _____ .

NOTE: There may be fees for provision of any or all requested information per Georgia State Law. Under most circumstances, the law permits up to 30 days for record requests to be processed, however records for treatment purposes can be immediately faxed to the patient's healthcare provider when requested.

❑ This use or disclosure is for a marketing function for which a Columbus Regional Health entity receives direct or indirect remuneration from a third party.