AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ Piedmont Hospital	☐ Piedmont Fayette Hospital	☐ Piedmont Mountainside Hospital	☐ Piedmont Newnan Hospital	☐ Piedmont Medical Care Corporation	☐ Piedmont Heart Institute
Health Information Mgt	*Health Information Mgt*	*Health Information Mgt*	*Health Information Mgt*	*Health Information Mgt*	*Health Information Mgt*
1968 Peachtree Road, NW	1255 Highway 54 West	1266 Highway 515 South	P.O. Box 997	2727 Paces Ferry Road	95 Collier Road
Atlanta, GA 30309	Fayetteville, GA 30214	Jasper, GA 30143	Newnan, GA 30264	Suite 1-1100	Suite 2045
				Atlanta, GA 30339	Atlanta, GA 30309
(404) 605-3280	(770) 719-7053	(706) 301-5455	(770) 304-4181	(770) 801-2550	(404) 605-5161
Fax (404) 605-1555	Fax (770) 719-6821	Fax (706) 301-5353	Fax (770) 304-4218	Fax (678) 244-8201	Fax (404) 609-6643

I hereby request and authorize (*print name of hospital/physician*): ______________________________ to:
(*initial **one** or **more** choices below as desired*)

____ Provide **copies** of my records checked below to:
(initial) Name (*receiving person/party*): ______________________________
Address: ______________________________
Fax #: ____________________ Phone # (*required to verify Fax#*): ____________________

____ Permit **review** of my records checked below by: *(name):* ______________________________
(initial)

____ Permit (*person's name*) ____________________ to be **present** during my: ☐ consultation ☐ exam ☐ procedure/surgery
(initial) *(please check appropriate box above)*

____ Use/disclose PHI as described: ______________________________
(initial)

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

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but **may include** other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

- ☐ **Entire Medical Record***
- ☐ **Abstract of Record****
- ☐ **Financial Record**
- ☐ **Pathology Slides/Blocks**
- ☐ **Radiology Films**
- ☐ Ambulance Record
- ☐ Autopsy Report
- ☐ Cardiac Cath Report
- ☐ Consent Forms
- ☐ Consultation Reports
- ☐ Discharge Summary Reports
- ☐ Doctors Orders
- ☐ Electro Cardiogram (ECG/EKG) Reports
- ☐ Emergency Room Record
- ☐ Face Sheet
- ☐ Gastro Intestinal (GI) Lab Report
- ☐ History and Physical Report
- ☐ Laboratory Test Results
- ☐ Medication Records
- ☐ Neurodiagnostic Reports
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Physical/Occupational Therapy (PT/OT) Notes
- ☐ Radiology Reports
- ☐ Speech-Language Pathology Reports
- ☐ Treatment Plan
- ☐ **Diagnostic Photos – Specify**____________________
- ☐ **Other – Specify**____________________
- ☐ **Notes – Specify**____________________

* Entire Medical Record includes all items NOT in bold print.
**An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

Purpose of Use or Disclosure: ☐ At the request of the individual (patient)
☐ Other______________________________

The following information is needed to assist the provider in locating the patient's records:

Patient's Full Name: ______________________________ Patient's SSN: ____________________
Maiden/Other Name: ______________________________ Patient's Date of Birth: ____________________
Patient's Phone # (Home): ____________________ (Work): ____________________ (Cell): ____________________
Current Address: ______________________________

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. Piedmont Providers 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** ______________________________

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

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. 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 Piedmont Provider receives direct or indirect remuneration from a third party.