

Medical Record Number: \_\_\_\_\_  
(for internal purposes)

# EMORY HEALTHCARE

## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION HEALTH INFORMATION MANAGEMENT DEPARTMENT

Patient Name: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

Previous Name, if applicable: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

### 1. EMORY HEALTHCARE FACILITY/FACILITIES:

I authorize representatives from the following facility/facilities to disclose the health information as directed below:

**(Check one or more):**

- |   |   |
|---|---|
| <input type="checkbox"/> The Emory Clinic                         | <input type="checkbox"/> Emory Johns Creek Hospital                       |
| <input type="checkbox"/> Emory University Hospital                | <input type="checkbox"/> Emory University Hospital Midtown                |
| <input type="checkbox"/> Center for Rehab. Medicine               | <input type="checkbox"/> Emory University Orthopaedics and Spine Hospital |
| <input type="checkbox"/> Emory Children's Center                  | <input type="checkbox"/> Wesley Woods Health Center                       |
| <input type="checkbox"/> Emory Specialty Associates               | <input type="checkbox"/> Wesley Woods Geriatric Hospital                  |
| <input type="checkbox"/> Dialysis Access Center of Atlanta        | <input type="checkbox"/> Wesley Woods Outpatient Clinic                   |
| <input type="checkbox"/> Saint Joseph's Hospital of Atlanta       | <input type="checkbox"/> Budd Terrace                                     |
| <input type="checkbox"/> The Medical Group of Saint Joseph's, LLC | <input type="checkbox"/> Other: _____                                     |

### 2. RECEIVING PARTY AND METHOD OF DELIVERY:

- Mail (Complete info below)
- Pick up (List by whom below)
- EHC Electronic Release of Information Request Website (Please provide email address above and see attached instructions)
- Via Email (Please provide email address above)

Name: Hoosier Services Inc.

Address: 18032 Lemon Dr, Ste C-618

City: Yorba Linda State: CA Zip Code: 92886

Telephone Number: 800.882.4156 fax 800.882.4957 Email: service@hoosierservicesinc.com

Fax Number (continuing patient care support only): \_\_\_\_\_

### 3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

Complete medical record (Please specify dates of service) \_\_\_\_\_

**OR**

Partial Medical Record (Please specify records below)

Electronic Continuity of Care/Electronic Abstract (please specify dates of service) \_\_\_\_\_

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

Information	Dates	Information	Dates
<input type="checkbox"/> History & physical	_____	<input type="checkbox"/> Office notes/Progress 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"/> Pathology slides	_____
<input type="checkbox"/> X-rays	_____	<input type="checkbox"/> EKG reports	_____
<input type="checkbox"/> CD/Films	_____	<input type="checkbox"/> Photo/Videos	_____
<input type="checkbox"/> Cath Record	_____	<input type="checkbox"/> ED Record	_____
<input type="checkbox"/> Itemized Bill	_____	<input type="checkbox"/> Rhythm Strips	_____
<input type="checkbox"/> Other (Please specify dates of service):	_____	<input type="checkbox"/> Pathology Slides	_____

### 4. PURPOSE OF DISCLOSURE

- At my request
- Other: Life Insurance purposes

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5. **EXPIRATION OF AUTHORIZATION**

Unless I request in writing otherwise, I understand that this authorization will expire on \_\_\_\_\_  
(Insert expiration date or event). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

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 my written revocation to the Medical Records Department(s) of the Emory Healthcare facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Emory Healthcare, Inc. Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. **RE-DISCLOSURE**

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care 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.

8. **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.

9. **REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE**

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 Emory Healthcare may decline to treat me if I refuse to sign this authorization 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 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 workers compensation examination).

10. **RELEASE AND WAIVER**

If the health information that I have requested Emory Healthcare 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 Emory Healthcare, each of the Emory Healthcare 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 Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
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 PATIENT'S REPRESENTATIVE AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD**