

# Emory-Adventist Hospital

## AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION FORM

Patient Name: \_\_\_\_\_ S. S. # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Patient Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

*To be completed by requester:*     Pick Up     Mail     Fax     Other: \_\_\_\_\_

If requested health information is needed for a doctor's appointment please specify date/time: \_\_\_\_\_

**The following organization is authorized to disclose patient health information as described.**

Emory Adventist Hospital at Smyrna

3949 South Cobb Drive

Smyrna, Georgia 30080

(770) 801-6681

Admission/Discharge Date(s): \_\_\_\_\_

**Portions of Record needed- Check applicable sections:**

<input type="checkbox"/> Face Sheet	<input type="checkbox"/> ER Record	<input type="checkbox"/> Physician's Progress Notes
<input type="checkbox"/> Consent Form(Condition of Treatment)	<input type="checkbox"/> Therapy Records	<input type="checkbox"/> Physician's Orders
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> HIV Testing / Information
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Drug/Alcohol Test Results _____
<input type="checkbox"/> Operative Report	<input type="checkbox"/> EKG	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Consultations	<input type="checkbox"/> *Abstract

*Radiology films, cardiology films, and billing information must be requested and picked up from the specific department.*

Reason for requesting information: \_\_\_\_\_

*Requests may be subject to copying fee*

**This information may be disclosed to and used by the following individual or organization:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

*Records will be faxed to Health Care Providers for urgent medical care only.*

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 Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days): \_\_\_\_\_ . If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative/Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Authorized Representative/Parent: \_\_\_\_\_

Authority to sign on behalf of patient is authorized by: \_\_\_\_\_

Address and Phone # of Authorized Representative/Parent: \_\_\_\_\_

Witness

by: \_\_\_\_\_

(Picture ID required to verify identity)

\*Abstract consists of face sheet, discharge summary, history & physical, consults, operative notes, pathology, and diagnostic test.