

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



THE EMORY CLINIC, INC.  
1525 CLIFTON ROAD

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION  
TO EMORY HEALTHCARE**

**TO BE COMPLETED IF RECORDS ARE BEING REQUESTED FROM ANOTHER FACILITY TO BE SENT TO AN EMORY  
HEALTHCARE ENTITY**

Patient Name (Please Print): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

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

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

**1. RELEASING FACILITY/FACILITIES:**

NAME OF FACILITY RECORDS BEING REQUESTED FROM (PLEASE PRINT)

ADDRESS STREET CITY ZIP

**2. RECEIVING PARTY**

Please send my health information to:

Name: The Emory Clinic Preventive Cardiology

Address: 1525 Clifton Rd Suite 209 2<sup>nd</sup> floor

City: Atlanta State: GA Zip Code: 30322

Fax Number: 404-778-2998

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

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

**OR**

Partial medical record (Please specify records below)

**Information**

**Dates**

**Information**

**Dates**

- History & physical \_\_\_\_\_
- Consultations \_\_\_\_\_
- Discharge summary \_\_\_\_\_
- Lab results \_\_\_\_\_
- X-rays \_\_\_\_\_
- Other (Please specify dates of service): \_\_\_\_\_

- Office notes \_\_\_\_\_
- Operative reports \_\_\_\_\_
- Pathology reports \_\_\_\_\_
- EKG reports \_\_\_\_\_

CONTINUE ON REVERSE SIDE

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**4. PURPOSE OF DISCLOSURE**

- At my request
- Other: \_\_\_\_\_

**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.

**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.

**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

\_\_\_\_\_  
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**