



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

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION  
MEDICAL RECORDS DEPARTMENT**

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Previous Name, if applicable: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**1. EMORY HEALTHCARE FACILITY/FACILITIES:**

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

*Check only one: (separate request form required for records from each facility desired)*

- |  |   |
|--|---|
| <input type="checkbox"/> The Emory Clinic                  | <input type="checkbox"/> Emory University Hospital Midtown (formerly Crawford Long) |
| <input type="checkbox"/> Emory University Hospital         | <input type="checkbox"/> Wesley Woods Geriatric Hospital                            |
| <input type="checkbox"/> Center for Rehab. Medicine        | <input type="checkbox"/> Wesley Woods Outpatient Clinic                             |
| <input type="checkbox"/> Emory Children's Center           | <input type="checkbox"/> Wesley Woods Long Term Care Hospital                       |
| <input type="checkbox"/> Emory Medical Affiliates          | <input type="checkbox"/> Budd Terrace   |
| <input type="checkbox"/> Dialysis Access Center of Atlanta | <input type="checkbox"/> Emory University Orthopedic and Spine Hospital             |

**2. RECEIVING PARTY**

Please send my health information to:

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

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

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

\*Fax Number: \* for medical purposes only (emergent or in office) \_\_\_\_\_

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

- Complete medical record (*Please specify dates of service*) \_\_\_\_\_
- OR -*
- Partial medical record (*Please check specific sections needed below*)
- You must check this box if you are also requesting Billing Records*

<b>Information</b>	<b>Dates</b>	<b>Information</b>	<b>Dates</b>
<input type="checkbox"/> History & physical	_____	<input type="checkbox"/> Office 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"/> EKG reports	_____
<input type="checkbox"/> X-ray Reports	_____		
<input type="checkbox"/> CD / Films	_____		

Other (*Please specify content and dates of service*): \_\_\_\_\_



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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.

**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 for 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

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