RESET

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):

- ❑ The Emory Clinic
- ❑ Emory Warner Robins ❑Clinic ❑Hospital
- ❑ Emory Perry ❑Clinic ❑Hospital
- ❑ Emory University Hospital
- ❑ Center for Rehab. Medicine
- ❑ Emory Children's Center
- ❑ Emory Specialty Associates
- ❑ Dialysis Access Center of Atlanta
- ❑ Emory Saint Joseph's Hospital of Atlanta
- ❑ Other: _____
- ❑ The Medical Group of Saint Joseph's, LLC
- ❑ Emory Johns Creek Hospital
- ❑ Emory University Hospital Midtown
- ❑ Emory University Orthopaedics and Spine Hospital
- ❑ Emory University Hospital at Wesley Woods
- ❑ Emory Decatur Hospital
- ❑ Emory Long Term Acute Care
- ❑ Emory Hillandale Hospital
- ❑ DeKalb Medical Physician Group

2. **RECEIVING PARTY, FORMAT, AND METHOD OF DELIVERY:**

FORMAT:
- ❑ On Paper
- ❑ On CD
- ❑ USB Drive

METHOD OF DELIVERY:
- ❑ Via MyChart
- ❑ Mail (Complete info below)
- ❑ Pick up (List by whom below)
- ❑ EHC Electronic Release of Information Request Website (Please see attached instructions)
- ❑ Via Email (Please provide email address above)
- ❑ Via EHI Export

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Fax Number (continuing patient care support only):_____

3. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**
- ❑ Complete medical record *(Please specify dates of service)*_____
- ❑ Partial Medical Record *(Please specify records below)*
- ❑ Continuity of Care/Abstract *(please specify dates of service)* _____
- ❑ *You must check this box if you are also requesting Billing Records*

Information	Dates	Information	Dates
❑ History & physical	_____	❑ Office notes/Progress notes	_____
❑ Consultations	_____	❑ Operative reports	_____
❑ Discharge summary	_____	❑ Pathology reports	_____
❑ Lab results	_____	❑ Pathology slides	_____
❑ Cath Record	_____	❑ EKG reports	_____
❑ Itemized Bill	_____	❑ Photo/Videos	_____
❑ Accounting of Disclosure	_____	❑ ED Record	_____
❑ Other *(Please specify dates of service):*		❑ Rhythm Strips	_____
		❑ Pathology Slides	_____

Image Request
- ❑ Radiology
- ❑ Heart and Vascular _____

4. **PURPOSE OF DISCLOSURE**
- ❑ At my request Need Records Certified ❑ Yes ❑ No
- ❑ Other: _____

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5. **Important Notice**

If you are requesting your medical information via e-mail, please be sure that you have provided us with an accurate e-mail address. E-mail and attachments will be sent to you in an encrypted format with instructions on how you retrieve the information. Once you receive the e-mail we encourage you to maintain the information in a secure manner and use caution when forwarding or allowing access to your e-mail. Also, the CD or flash drive you receive containing your medical health information may not be encrypted or password protected. Once you have received your medical information from Emory Healthcare we encourage you to take precautions to protect the data on the device through encryption or storing the device in a secure manner. By choosing to receive **your health information** on a CD or flash drive, you are acknowledging and accepting these risks.

6. **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. **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 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.

8. **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.

9. **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.

10. **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).

11. **Waiver**

If the health information that I have requested Emory Healthcare to disclose contains any information related to certain infectious diseases (including, without limitation, HIV/AIDS confidential information), substance abuse and/or mental health, I consent to the disclosure of such information by Emory Healthcare and waive any privileges or confidentiality with regard to such disclosures for the purpose(s) of releasing it to the party or parties authorized above.

This authorization does not apply to records protected by 42 C.F.R. Part 2 (substance use disorder treatment records). A separate, specific consent is required for disclosure of such records. This authorization may still be used for other substance use information that is not subject to Part 2 protections

_____	_____	_____
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