

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"/> Emory University Hospital at Wesley Woods |
| <input type="checkbox"/> Emory Specialty Associates | <input type="checkbox"/> Budd Terrace |
| <input type="checkbox"/> Dialysis Access Center of Atlanta | <input type="checkbox"/> Emory Decatur Hospital |
| <input type="checkbox"/> Emory Saint Joseph's Hospital of Atlanta | <input type="checkbox"/> Emory Long Term Acute Care |
| <input type="checkbox"/> The Medical Group of Saint Joseph's, LLC | <input type="checkbox"/> Emory Hillandale Hospital |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> DeKalb Medical Physician Group |

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

FORMAT:

- On Paper
- On CD
- Flash Drive

METHOD OF DELIVERY:

- Mail (Complete info below)
- Pick up (List by whom below)
- EHC Electronic Release of Information Request Website (In order to receive records via the electronic website, you must create an account through the website, then submit your request via the website. Please see attached instructions)
- Via Email (Please provide email address above) Please note, due to file size limits for our organization, records sent via email are restricted to a small number of pages.

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) _____

OR

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
<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 Need Records Certified Yes No

Other: _____

Medical Record Number: _____
(for internal purposes)

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 EHC 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, 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.

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. **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



Release of Information Policies

1. To properly assist in handling your request for medical information, please completely fill out both pages of the authorization form and sign the patient fee sheet.
2. Provided the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, your request for information will be submitted for processing within 24 to 48 hours after receipt and delivered by mail or electronic (eDelivery) within 7 to 10 business days. If needed, the records may be picked up and you will be notified once the records are ready. This policy is nullified for medical emergencies only.
3. All authorizations must be dated after discharge and signed by the patient, unless he/she is a minor, deceased, physically and/or mentally impaired, or has appointed a Durable Healthcare Power of Attorney or has a court appointed guardian. Due to State and Federal laws, no exceptions will be made.
4. Written authorization is required.

Release of Information Fees for Patients

**Delivered in electronic format via CD, Flash Drive, or Electronic Website:
\$6.50 flat fee. Plus sales tax and actual postage if mailed.**

**Delivered in paper format:
\$0.07 per page. Plus, if applicable: \$0.90 labor cost, \$0.05 per page supply cost, actual postage if mailed, and sales tax.**

***Please Note: If the format of the original record is Hybrid (Part electronic & Part paper), the fees will be a combination of both of the above.**

Certification fee: \$9.70

Radiology Film CD: \$25 flat fee

Continued Patient Care: An Abstract of the record can be sent directly to a healthcare provider at no cost.

****Please Note: In order to process requests for release of medical records on its behalf, Emory Healthcare has contracted with a vendor that is subject to HIPAA privacy and confidentiality requirements.**

Your questions regarding Release of Information are welcomed. Please contact the facility directly for any questions.

By signing below, I acknowledge that I have read the above procedures regarding the release of medical records.

Patient/Representative Signature

Date of Signature