Piedmont AUGUSTA

PLACE PATIENT LABEL CAREFULLY HERE

Authorization For Use/Disclosure of Protected Health Information

PATIENT INFORMATION: The following information Is needed to assist the provider in locating the patient's medical record

Patient Name: Patient Date of Birth:

Patient Street Address: I Phone:

City/State/Zip: I Cell/Alternate#:

Email Address:

REQUEST AUTHORIZATION: I hereby authorize Piedmont Healthcare to disclose records from: 0 Piedmont Augusta/Summerville 0 Piedmont McDuffie 0 St. Joseph's//Trinity Hospital 0 Physician Practice Name : 0 Prompt Care Name :

DISCLOSURE: Records to be disclosed to the person or entity listed below by: O Mail 0 Secure E-mail Portal 0 My Chart OCD 0 Pick up at Piedmont Augusta Location

Person Authorized to pick up records on patient behalf: _____

0 Patient/Representative request O 3rd Party request

Name:

Street Address:

City/State/Zip:

Phone: I Fax:

Purpose:

DESCRIPTION OF INFORMATION FOR RELEASE: Please provide dates of service and check applicable boxes below

The applicable dates of service:

0 Entire Medical Record	0 Emergency Room Record	O Pathology Report	0 Operative Report
0 Abstract of Record'	0 Cardiac Gath Report/CD	0 Radiology Film/CD	0 UBO4
0 Laboratory Data	OEKG	0 Discharge Summary	0 Itemized Bill O Other:

_____

• An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports and diagnostic test results.

Authorization For Use/Disclosure of Protected Health Information

I understand that the information that I am authorizing the above Piedmont Provider(s) to use/disclose may include information related to the diagnosis or treatment of mental illness, substance abuse, chemical dependency, and alcohol abuse, including privileged psychiatric or psychological communications and other detailed mental health information; infectious diseases, such as HIV/AIDS, venereal disease, tuberculosis or hepatitis; and genetic testing or information derived from genetic testing. I hereby waive any privilege concerning such information for the disclosure to the person or entity I have authorized above. I understand that the information used/disclosed pursuant to this authorization will not include psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing contents of conversation during a counseling session that are kept separate from the rest of the medical record.

I understand that Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations.

I understand that unless otherwise limited by state or federal regulations, I may revoke this authorization at any time by presenting my revocation in writing to the Piedmont Healthcare entity noted above, except to the extent that such entity has taken action in reliance on this authorization. I understand that a revocation form may be obtained from the Piedmont Healthcare entity noted above.

I understand that this authorization is specific to the information, purpose and date(s) of services indicated above. I further understand that this authorization is valid for 90 days from today's date and will expire at that time unless another date is written here ;

Lastly, I understand that Piedmont Providers shall not condition treatment on the receipt of this authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party, for example a fitness- for-duty exam.

Note: There may be fees for provision of the information requested; however, records for treatment purposes may be faxed to the patient's healthcare provider when requested at no charge. Under most circumstances, applicable law permits up to thirty (30) days for record requests to be processed.

Patient or Legal Representative signature _____ Please PRINT name _____ Today's date _____ Time _____

As Legal Representative, my relationship to the patient is: _____. Any document proving such authority must be attached.

The patient is unable to sign because: _____