



Authorization For Use/Disclosure of Protected Health Information

PATIENT INFORMATION

The following information is needed to assist the provider in locating the patient's records:

Patient full name: _____ Date of birth: _____

Maiden/other name: _____ Current address: _____

Patient phone # (home): _____ (work): _____ (cell): _____

REQUEST AUTHORIZATION

I hereby request and authorize Health Information Management at (choose all applicable):

- | | | | |
|---|---|-----------------------|---------------------|
| <input type="checkbox"/> Piedmont Athens Regional | 1199 Prince Avenue, Athens, GA 30606 | Phone: (706) 475-3361 | Fax: (706) 475-6961 |
| <input type="checkbox"/> Piedmont Atlanta Hospital | 1968 Peachtree Road, NW, Atlanta, GA 30309 | Phone: (404) 605-3280 | Fax: (404) 605-5551 |
| <input type="checkbox"/> Piedmont Fayette Hospital | 1255 Highway 54 West, Fayetteville, GA 30214 | Phone: (770) 719-7053 | Fax: (770) 719-6821 |
| <input type="checkbox"/> Piedmont Heart Institute | 275 Collier Road Suite 500, Atlanta, GA 30309 | Phone: (404) 605-5570 | Fax: (404) 355-4739 |
| <input type="checkbox"/> Piedmont Henry Hospital | 1133 Eagle's Landing Parkway, Stockbridge, GA 30281 | Phone: (678) 604-5844 | Fax: (678) 604-5076 |
| <input type="checkbox"/> Piedmont Medical Care Corporation | 2727 Paces Ferry Road Suite 1-1100, Atlanta, GA 30339 | Phone: (678) 423-6633 | Fax: (404) 609-7543 |
| <input type="checkbox"/> Piedmont Mountanside Hospital | 1266 Highway 515 South, Jasper, GA 30143 | Phone: (706) 301-5455 | Fax: (706) 301-5353 |
| <input type="checkbox"/> Piedmont Newnan Hospital | 745 Poplar Road, Newnan, GA 30265 | Phone: (770) 400-4181 | Fax: (770) 304-4218 |
| <input type="checkbox"/> Piedmont Newton Hospital | 5126 Hospital Drive, NE, Covington, GA 30014 | Phone: (770) 385-4235 | Fax: (678) 625-2068 |

Other: _____

_____ (initial)	To provide copies of my records checked below to: Name (receiving person/party): _____ Fax #: _____ Address: _____ Phone #: _____ (required to verify Fax #)
_____ (initial)	To permit review of my records checked below by (person's name): _____
_____ (initial)	To use/disclose PHI as described: _____

This authorization applies to records or PHI access from the following date or dates of service: _____

PURPOSE OF DISCLOSURE

- At the request of the individual (patient)
 For a marketing function for which a Piedmont Provider receives direct or indirect remuneration from a third party.
 Other: _____

DESCRIPTION OF INFORMATION TO BE RELEASED

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Pathology Slides/Blocks | <input type="checkbox"/> Financial Record |
| <input type="checkbox"/> Abstract of Record* | <input type="checkbox"/> Cardiac Cath Report/CD | <input type="checkbox"/> Radiology Films/CD | |
- Other - Specify: _____

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

AUTHORIZATION SIGNATURES

I understand that the 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 except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from Health Information Management. The completed revocation must be presented to Health Information Management. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. 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, fitness-for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here:** _____

Patient or Legal Representative signature	Please PRINT name	Today's date	Time
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As Legal Representative, my relationship to the patient is: _____. Any document proving such authority must be attached.
The patient is unable to sign because: _____

NOTE: There may be fees for provision of any or all requested information. Under most circumstances, the law permits up to 30 days for record requests to be processed, however records for treatment purposes can be immediately faxed to the patient's healthcare provider when requested.