



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. Completed Authorization Requests can be submitted via email to RecordsRequest@piedmont.org.

Patient Name:		Patient Date of Birth:
Patient Street Address:		Phone:
City/State/Zip:	Email Address:	Cell/Alternate #:

REQUEST AUTHORIZATION: I hereby authorize Piedmont Healthcare to disclose records from facility checked below

Piedmont Provider	Phone	Fax	Piedmont Provider	Phone	Fax
<input type="checkbox"/> Piedmont Athens Regional Medical Center	706-475-3361	1-833-605-1230	<input type="checkbox"/> Piedmont Henry Hospital	678-604-5844	1-833-605-2368
<input type="checkbox"/> Piedmont Atlanta Hospital	404-605-3280	1-833-605-2063	<input type="checkbox"/> Piedmont Macon	1-888-801-9165	404-845-3919
<input type="checkbox"/> Piedmont Augusta Hospital	706-774-2281	706-774-8737	<input type="checkbox"/> Piedmont Macon Northside	1-888-801-9165	404-845-3919
<input type="checkbox"/> Piedmont Augusta – Summerville	706-774-2281	706-774-8737	<input type="checkbox"/> Piedmont McDuffie Hospital	706-774-2281	706-774-8737
<input type="checkbox"/> Piedmont Cartersville Hospital	1-888-801-9165	404-845-3918	<input type="checkbox"/> Piedmont Medical Care Corporation	678-423-6633	404-614-1607
<input type="checkbox"/> Piedmont Columbus Regional – Midtown	706-571-1709	1-833-605-2184	<input type="checkbox"/> Piedmont Mountainside Hospital	706-301-5455	1-833-605-3477
<input type="checkbox"/> Piedmont Columbus Regional – Northside	706-494-2177	1-833-605-2184	<input type="checkbox"/> Piedmont Newnan Hospital	770-400-4181	1-833-605-3261
<input type="checkbox"/> Piedmont Eastside Hospital	1-888-801-9165	404-845-3920	<input type="checkbox"/> Piedmont Newton Hospital	770-385-4235	404-845-3906
<input type="checkbox"/> Piedmont Fayette Hospital	770-719-6825	1-833-605-3204	<input type="checkbox"/> Piedmont Rockdale Hospital	770-918-3372	1-833-605-3495
<input type="checkbox"/> Piedmont Heart Institute	404-605-5570	404-614-1608	<input type="checkbox"/> Piedmont Walton Hospital	770-267-1880	1-833-605-3495

DISCLOSURE: Records to be disclosed to the person or entity listed below by: Mail Secure E-mail Portal Pick up at location checked above

Name:	
Street Address:	
City/State/Zip:	
Phone:	Fax:
Purpose:	<input type="checkbox"/> Patient/Representative request <input type="checkbox"/> Other:

DESCRIPTION OF INFORMATION FOR RELEASE: List your date of service here:

<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"/> Certified Copy
<input type="checkbox"/> Abstract of Record*	<input type="checkbox"/> Cardiac Cath Report/CD	<input type="checkbox"/> Radiology Film/CD	<input type="checkbox"/> 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 checked 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 checked 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: _____