D10013

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Piedmont Athens Regional Medical Center, Inc.
d/b/a Piedmont Athens Regional ("PAR")
1199 Prince Avenue
Athens, Georgia 30606

FOR INTERNAL USE ONLY:

_____ _____
Medical Record Number Patient's Account Number

PATIENT INFORMATION:

_____ _____ _____
Legal Name Date of Birth Social Security Number (last 4 digits)

_____ _____
Street Address City, State, Zip Code

_____ _____
Phone Number Home Cell Other (Date(s) of Treatment)

I HEREBY AUTHORIZE PAR TO:

(Check one below)

_____RELEASE INFORMATION TO: **_____OBTAIN INFORMATION FROM:**

_____
(Attorney/Physician/Institution/Agency/Individual)

_____ _____
(Street Address) (City, State, Zip Code)

_____ _____
(Telephone Number) (Fax Number)

DELIVERY METHOD: Will Pick Up_____Mail to Address Above____Fax _____

FOR THE PURPOSE OF: _____ Healthcare Facility _____ Insurance _____ Legal _____ Permanent Release

_____ Personal _____ Physician _____ Disability _____ Pre-Surgical Evaluation

_____ Other (Please specify): _____

DT0013

Unless indicated by specific request checked below, I permit the release of any and all information including, if any, information concerning drug/alcohol abuse records, venereal disease and other statutorily protected diseases, psychiatric records (excluding psychotherapy notes), or AIDS/HIV testing treatment records.

Please Check Specific Information Requested for Release:

_____ All PHI in medical record _____ ER Report(s) _____ Discharge Summary

_____ Operative Report _____ History and Physical _____ Pathology Report(s)

_____ Progress/Office Note(s) _____ Laboratory Report(s) _____ Radiology Report(s)

_____ Other (Please Specify) _____ _____ Images

_____ *Psychotherapy Note(s) _____ Cardiac Records

***PATIENT INITIALS:_____ *If this is a request for psychotherapy notes, I authorize these records to be released along with the other requested information.**

I understand that:

- I may revoke this authorization at any time in writing and present my written revocation to the PAR facility.
- The revocation will not apply to information that has already been released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I may refuse to sign this authorization.
- Disclosure of health information is voluntary.
- I need not sign this authorization to ensure treatment nor will it affect my payment status.
- Any disclosure of information carries with it the potential for an unauthorized redisclosure.
- I may inspect or have a copy of the information described on this form if I ask for it.
- I get a copy of this form after I sign it.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . **If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days.**

If I have questions about the disclosure of my protected health information, I can contact the Health Information Management Department or the Compliance Department. I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____ _____

(Signature of Patient or Legal Representative) Date Time

If signed by legal representative, relationship of individual to patient: _____

_____ _____ _____

(Signature of Witness) Date Time

For Internal Use Only:

Medical Records copied and forwarded with patient Medical Records faxed to facility indicated above HIM to process

Released/Received By: _____ Date _____ Time_____