Piedmont HEALTHCARE 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):

❑ **Piedmont Atlanta Hospital**	1968 Peachtree Road, NW, Atlanta, GA 30309	Phone: (404) 605-3280	Fax: (404) 605-5551
❑ **Piedmont Fayette Hospital**	1255 Highway 54 West, Fayetteville, GA 30214	Phone: (770) 719-7053	Fax: (770) 719-6821
❑ **Piedmont Heart Institute**	275 Collier Road Suite 500, Atlanta, GA 30309	Phone: (404) 605-5570	Fax: (404) 355-4739
❑ **Piedmont Henry Hospital**	1133 Eagle's Landing Parkway, Stockbridge, GA 30281	Phone: (678) 604-5844	Fax: (678) 604-5076
❑ **Piedmont Medical Care Corporation**	2727 Paces Ferry Road Suite 1-1100, Atlanta, GA 30339	Phone: (678) 423-6633	Fax: (404) 609-7543
❑ **Piedmont Mountainside Hospital**	1266 Highway 515 South, Jasper, GA 30143	Phone: (706) 301-5455	Fax: (706) 301-5353
❑ **Piedmont Newnan Hospital**	745 Poplar Road, Newnan, GA 30265	Phone: (770) 400-4181	Fax: (770) 304-4218
❑ **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.

❑ Entire Medical Record ❑ Emergency Room Record ❑ Pathology Slides/Blocks ❑ Financial Record
❑ Abstract of Record* ❑ Cardiac Cath Report/CD ❑ 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**
_____	_____	_____	_____

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.