WELLSTAR Health System

For Internal Purposes
Account Number: _____
Medical Record Number: _____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security Number (last 4 digits only): _____

Previous Name, if applicable: _____

Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

1. WELLSTAR HEALTH SYSTEM FACILITY / FACILITIES

I authorize representatives from the following facility / facilities to disclose the above-named individual's health information as directed below: *(Check one or more)*

- ❒ WellStar Cobb Hospital
- ❒ WellStar Douglas Hospital
- ❒ WellStar Kennestone Hospital
- ❒ WellStar Paulding Hospital
- ❒ WellStar Windy Hill Hospital
- ☑ WellStar Medical Group
  Name(s) of Provider(s): WellStar KSU Student Health Services
- ❒ Other: _____

2. RECEIVING PARTY

❒ Please send my health information to:

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Fax Number (healthcare provider only): _____

❒ I would like to pick up my medical records in person

❒ I authorize _____ to pick up my medical records in person.
(Name of person authorized to receive the record)

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED

❒ Complete medical record *(please specify dates of service)* _____

OR

❒ Partial medical record *(please specify records below)*

Information	Dates	Information	Dates
❒ History and Physical		❒ Office Notes	
❒ Consultations		❒ Operative Reports	
❒ Discharge Summary		❒ Pathology Reports	
❒ Lab Results		❒ EKG Reports	
❒ X-rays		❒ HIV / AIDS Information	
❒ Drug / Alcohol Abuse treatment		❒ Mental Health Treatment	

❒ Other: _____ *- please specify dates of service:* _____

❒ *You must check this box if you are also requesting Billing Records*

Original - Chart **Copy - Patient** **SPP #PS-93-01**

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4. PURPOSE OF DISCLOSURE

❒ My personal records ❒ Attorney ❒ Disability

❒ Other: _____

5. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, this authorization will expire on _____. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which it was signed.

(insert date or event)

6. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to the Health Information Management Department(s) of the WellStar Health System facility or facilities checked above. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee schedule may be viewed at www.wellstar.org.

8. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment. However, if I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that WellStar Health System may decline to treat me if I refuse to sign this information only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a pre-employment drug screen).

9. RE-DISCLOSURE

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

10. RELEASE AND WAIVER

If the health information that I have requested WellStar Health System to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above.

I also release WellStar Health System, each of the WellStar Health System facilities checked above and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

_____ _____

Signature of Patient (or Patient's Legal Representative) Date

_____

Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.