**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

1. **Patient Information**

Last Name: First Name: Middle Initial:

Date of Birth: Social Security No.:

Phone No.: E-mail Address: \_\_\_\_\_\_\_\_

Address: \_\_\_ Apt#: \_\_\_\_\_\_\_\_

City: State: Zip: ­­­

I request and authorize **Good Samaritan Health Center of Cobb** to disclose the healthcare records (including but not limited to procedures, lab results, medications) of the patient named above, as directed below:

1. **Recipient**

I would like to collect my records in person *(Please specify preference):*

Paper **OR** Jump Drive

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to collect my medical records in person.

*(Name of person authorized to collect medical records)*

Please send my records to:

Name: \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_

City: State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: ­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax No. *(Please provide for Healthcare Providers* ***only****)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Description of Health Information to be Disclosed:**

Complete Medical Record

**OR**

Partial Medical Record

|  |  |  |  |
| --- | --- | --- | --- |
| **Information** | **Dates** | **Information** | **Dates** |
| History and Physical |  | Office Notes |  |
| Consultations |  | Operative Reports |  |
| Discharge Summary |  | Pathology Reports |  |
| Lab Results |  | Cardiac Studies |  |
| Radiology Reports |  | HIV/AIDS Information |  |
| Drug/Alcohol Abuse Treatment |  | Mental Health Treatment |  |

**You must check this box if you are also requesting medical billing records.**

1. **Purpose of Disclosure:**

My personal records  Legal Investigation or Action  Insurance Eligibility/Benefits

Further Medical Care  Changing Physicians  Coordination of Care

Other *(please specify):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **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.

Medical Records Search & Retrieval Fee: **$25.00**

1. **Expiration of authorization**

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

*(Insert date or event)*

1. **Right to Revoke Authorization**

I understand that I have the 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 Medical Records Custodian of **Good Samaritan Health Center of Cobb**. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

1. **Refusal to Authorize Use and/or Disclosure**

I understand that the authorizing the use of the information above is voluntary. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

1. **Your Rights with Respect to this Authorization**

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Medical Records Custodian at 770-419-3120.

1. **Release And Waiver**

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care 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. Additionally, if the health information that I have requested **Good Samaritan Health Center of Cobb** 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 **Good Samaritan Health Center of Cobb** and their officers, physicians, trustees, agents, employees and volunteers from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

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| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient (or Patient’s Legal Representative) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Description of Authority to Act for Patient |