NH2493

NORTHSIDE HOSPITAL

English - Spanish - Korean

Patient Name (print first and last name): _____ Date of Birth: _____

Previous Name, if applicable: _____ Preferred Phone #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

1. WHO CAN RELEASE MY HEALTH INFORMATION:

I hereby authorize the facilities listed below* to disclose my health information to the person/entities listed in Section 2 ***(check one or more)***:

NORTHSIDE AFFILIATED FACILITIES:

- ☐ Northside Hospital Atlanta
- ☐ Northside Hospital Cherokee
- ☐ Northside Hospital Duluth
- ☐ Northside Hospital Behavioral Health Services
- ☐ Northside Hospital Forsyth
- ☐ Northside Hospital Gwinnett
- ☐ All Northside Hospitals (does not include Behavioral Health)
- ☐ Northside Affiliated Facility/Practice (specify name): _____

*I understand that my medical record may also include health information from other healthcare providers involved in my care.

☐ OTHER FACILITY – ***Not affiliated with Northside*** (Specify name, address and phone number of facility): _____

_____

2. WHO CAN RECEIVE MY HEALTH INFORMATION:

I authorize the person or facility listed below to receive the health information described in Section 3:

Name of Person/Facility: _____

Street Address: _____ City: _____

State: _____ Zip: _____

Telephone: _____ FAX: _____

3. WHAT HEALTH INFORMATION CAN BE DISCLOSED:

DATES OF SERVICE: From: _____ **To:** _____

Please check one option below	**Please specify below if the following records are also needed**
☐ Complete medical record	☐ Billing Records
☐ Abstract/Continuity of Care Summary	☐ Radiology Images
☐ **Partial medical record (Please specify requested records by checking below)** ☐ Physician Office Notes ☐ History & Physical ☐ Consultations ☐ Discharge Summary ☐ Operative/Procedure Reports ☐ Cardiology/EKG Reports ☐ Lab Results ☐ Radiology Reports ☐ Emergency Room Dept. Reports ☐ Radiology Images ☐ Progress Notes ☐ Pathology Reports ☐ Other: _____	

4. HOW INFORMATION SHOULD BE RELEASED:

- ☐ Pick up by ☐ patient or ☐ name of person picking up: _____
- ☐ US Mail via the address listed in Section 2.
- ☐ Email to email address: _____
- ☐ Fax to my healthcare provider (listed in Section 2) for continuity of care requests.

Need records certified: ☐ YES ☐ NO

5. THE REASON I WANT TO DISCLOSE MY HEALTH INFORMATION:

☐ Personal Use ☐ Attorney / Legal ☐ Continuity of Care (Medical Treatment) ☐ Insurance

☐ Disability ☐ Other (describe): _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

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6. **HOW LONG IS THIS AUTHORIZATION VALID?** This authorization will expire 6 months from the date it is signed unless I write another date here: _____

7. **HOW DO I REVOKE THIS AUTHORIZATION?** I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it. If I am authorizing release of records by Northside, this authorization can be revoked by submitting a written request to the Health Information Services Department of Northside Hospital at 1000 Johnson Ferry Road, Atlanta, Georgia, 30342. If I am authorizing a non-Northside person or facility to release records, I should contact that person or facility for instructions.

8. **WHAT ARE THE FEES FOR RELEASING RECORDS?** Federal and state laws allow for reasonable, cost-based fees to be charged for the copying and provision of patient records. If fees apply to my request, I will be responsible for payment of these fees.

9. **WILL MY RECORDS REMAIN CONFIDENTIAL AFTER DISCLOSURE?** Medical records and information that are disclosed pursuant to this authorization may be further disclosed by the recipient and will no longer be subject to protection under the federal privacy laws and regulations. Any electronic format of my health information may not be encrypted or password protected. I am responsible for taking precautions to protect the data and storing it in a secure manner. I hereby release Northside and its agents and employees from any and all liabilities, responsibilities, damages, and claims that might arise from the release, receipt, and/or re-disclosure of these medical records and the information included therein from a Northside facility.

10. **CAN I REFUSE TO AUTHORIZE DISCLOSURE?** Authorizing the use or disclosure of the information above is voluntary and Northside or my health care provider may not condition treatment upon my signing of this authorization, except in limited circumstances in which (1) such conditioning is permitted for research-related treatment, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers' compensation examination).

11. **WAIVER:** If the health information I have requested to be disclosed includes any information related to mental health, substance abuse, testing/treatment of infectious diseases (including, without limitation, HIV/AIDS confidential information, venereal disease, tuberculosis, or hepatitis) or genetic testing, I consent to the disclosure of such sensitive health information by Northside or my health care provider and waive any privilege regarding such information for the purpose of releasing it to the person or facility named in Section 2. If I am a birth mother signing this authorization on behalf of my minor child, I acknowledge that the minor's records may also include my sensitive health information related to mental health, substance abuse, infectious disease (including, without limitation, HIV/AIDS confidential information, venereal disease, tuberculosis, or hepatitis) or genetic testing, and I hereby consent to the disclosure of my sensitive health information in my minor child's record and waive any privilege concerning such information for the purpose of releasing it to the person or facility named in Section 2.

Note: Please read this form in its entirety and complete all applicable lines below. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) you are legally authorized to have access to the patient's medical records. ***You may be asked for additional documentation.***

_____ _____
Signature of Patient or Legal Representative Date/Time

_____
Relationship to Patient If Not the Patient

_____
Reason Patient Unable to Sign

_____ _____
Interpreter's Signature Date/Time
Note: If remote interpretation used (phone/iPad), record interpreter name, ID#

Interpreter Comments (optional):_____

_____

NOTICE TO PARTY RECEIVING SUBSTANCE ABUSE RECORDS: 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

Please return completed form via email to roirequest@northside.com or via fax to 404-250-8248