DT0013

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Return To:_____
_____
_____
_____

Athens Regional Health Services, Inc.
d/b/a Athens Regional Health System ("ARHS")
1199 Prince Avenue
Athens, Georgia 30606

PATIENT INFORMATION:

_____ _____ _____
Name Date of Birth Social Security Number

_____ _____
Street Address City, State, Zip Code

_____
Phone Number

FOR INTERNAL USE ONLY:

_____ _____
Medical Record Number Patient's Account Number

I HEREBY AUTHORIZE ARHS 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)

_____
(Date(s) of Treatment)

PLEASE INDICATE DELIVERY METHOD: ____ Will Pick Up ____ Mail to Address Above

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

_____ Personal _____ Physician _____ Disability ____ Pre-Surgical Evaluation

_____ Other (Please specify):_____

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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 ARHS 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.

AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE.

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 of Signature)

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

_____ _____
(Signature of Witness) (Date/Time of Signature)

_____ _____ _____
(Witness Street Address) (Witness Phone Number) (City, State, Zip Code)