



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
(Patient s Permission to Release Information in the Medical Record Page 1 of 2)

Patient Name: _____ Date of Birth: _____
Address: _____
Patient Number: _____
Phone #: _____

- Grady Health System (Grady) has my permission to use or give out certain information in my medical record — called “protected health information” (PHI). The information that Grady may give out is checked below.
- I understand that my PHI includes records that Grady gets from other doctors, medical offices, or hospitals where I have been a patient.
- I also understand that PHI may include information protected under Federal and State Law (such as information about alcohol, drug abuse, mental health, HIV treatment, and/or AIDS tests).

Information to be Used or Given Out:

Complete Medical Record

OR

The items checked below (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnosis, Treatment and/or Referral for Alcohol and/or Drug Abuse |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Photos, Videos, Digital or Other pictures |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Private Information about AIDS or HIV | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Mental Health Care or Services | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Psychotherapy Notes | |

Other (please specify):

Note: If this form covers psychotherapy notes, it cannot cover any other type of protected health information.

Person(s) with my permission to use or give out my information (for example: Medical Records Department, Finance Department, Public Relations Department):

Person(s) who may receive my information:



Atlanta, Georgia

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How my information will be used:

OR

I am asking for my PHI.

Expiration

My permission will expire on the date or following event: _____ .

How to Cancel This Authorization

I understand that I may cancel this Authorization by filling out a form and sending it to _____ . Grady staff will give me the form.

Authorization as a Condition to Treatment

I understand that I do not have to sign this Authorization to be treated at Grady, unless:

- I am treated at Grady only to give health information to a third party (such as for an employee physical exam), or
- I need treatment related to a research study. In this case, Grady will not treat me unless I sign this Authorization.

Potential Redisclosure

I understand that persons who get health information about me from Grady could give my information to others, unless Federal laws say they cannot. I give Grady permission to copy this Authorization and give to persons who get my health information from Grady.

I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person with permission to act on Patient's behalf. I will not hold Grady, its officers, trustees, employees, agents, or contractors responsible for anything that may happen from the use or release of my PHI.

_____	_____
Print Patient Name	Date

Patient Signature	

Print Patient's Authorized Representative Name	

Signature of Patient's Authorized Representative	

Relationship of the Representative to the Patient	

(Note: Please give a copy of the signed Authorization to Patient)