# Patient Authorization for Disclosure of Protected Health Information

**Instructions:** Please fill out form in its entirety. If any selection is incomplete, this form may be considered invalid and the request may not be processed. **By completing this form, I am granting Grady Health System ("Grady") permission to release/disclose certain information in my medical record (protected health information).**

Patient Name: _____ Previous/Maiden Name: _____
Date of Birth: _____ Last Four of SSN: _____
Address: _____ City: _____ State: _____ Zip:_____
Phone: _____ Email: _____

**I authorize the disclosure/release of my information:**

**To:** Name _____
Address_____
City/State/Zip_____
Phone/Fax_____/_____

**From:** Name_____
Address_____
City/State/Zip_____
Phone/Fax_____/_____

**I authorize Grady to disclose/release the following information:**
Date(s) of service requested: From _____ (date) to _____ (date).

**Information disclosed <u>may</u> contain information about alcohol/drug abuse, mental/behavioral health, sexually transmitted diseases, HIV and/or AIDS.**

| **Hospital Visits:** | **Office Visits:** | **Diagnostic Reports:** | **Diagnostic Imaging:** *Released on CD* |
|---|---|---|---|
| ☐ Entire Medical Record<br>☐ *Abstract of Records<br>☐ Diagnosis<br>☐ History and Physical<br>☐ Consultation Notes<br>☐ Other_____<br>☐ Operative Notes<br>☐ Progress Notes<br>☐ Radiology Reports<br>☐ Lab Reports<br>☐ Discharge Summary | ☐ Diagnosis<br>☐ Progress Notes<br>☐ History and Physical<br>☐ Consultation Report<br>☐ Immunization Records | ☐ Radiology Reports<br>☐ Lab Reports<br>☐ EKG/Cardiology Reports<br>☐ Pathology Reports | ☐ X-Ray<br>☐ CT Scan<br>☐ MRI<br>☐ Cardiac Imaging |

*Abstract of Record includes the history and physical, operative notes, consultation notes, and discharge summary

**The purpose of releasing or obtaining the above information is:**
☐ Continuity of Care ☐ Insurance/Billing ☐ Legal ☐ Personal ☐ Other:_____

**Release/Disclosure Format**

☐ Paper ☐ CD ☐ Electronic via Encrypted Email: _____

**Release/Disclosure Method**
☐ Email ☐ Mail ☐ Pick Up ☐ Fax (Continuity of Care Only)

**If records are to be picked up by the patient's representative, please list the name of the representative:**
_____

**By signing this Authorization form, I understand that:**

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I understand that I may revoke this authorization at any time by sending a written notice to Grady Health Information Management Department at the address noted below. I understand that the revocation will not apply to any PHI that has already been released in association with this authorization. The address can be found on page 2 (on the back) of this form.
- This authorization will expire one (1) year from the date of signing unless I revoke it in writing, or indicate an event or earlier date here: _____.
- 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 PHI 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.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I give Grady permission to copy this Authorization and give it to persons who receive my information.

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 Signed (required):** |
| **Patient Signature** | |
| **Print Patient's Authorized Representative Name** | **Date Signed (required):** |
| **Signature of Patient's Authorized Representative** | |

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

## Documentation Required to Release Medical Records

**To ensure we are releasing medical records to an authorized party, we ask that you make the following documentation available to us upon your request.**

**Patients Requesting Their Own Medical Records**:

- Patient Authorization for Disclosure of Health Information form signed by the patient
- Government issued photo identification (Driver's License, State ID card, Passport)

**Patient Representative Picking Up Medical Records Requested by Patient**:

- Patient Authorization for Disclosure of Health Information form signed by the patient
- Government issued photo identification of the patient **and** the patient's representative (Driver's License, State issued ID card, Passport)

**Third Party or Patient's Representative Requesting Medical Records**:

- Patient Authorization for Disclosure of Health Information form signed by the patient's representative.
- Government issued photo identification of the patient's representative (Driver's License, State issued ID card, Passport)
- Advance Directive for Healthcare (designating representative as Health Care Agent)
- Legal Guardian Designation or Conservatorship
- Death Certificate (if patient is deceased)
- Executer of Estate Documentation (if patient is deceased)
- Next of Kin Affidavit (if patient is deceased)
- Court Order, Subpoena, Production of Documents