Medical Record Number:\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(for internal purposes)*



AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION HEALTH INFORMATION MANAGEMENT DEPARTMENT



Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 digits of SSN:\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Name, if applicable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Emory Healthcare Facility/Facilities:**

I authorize representatives from the following facility/facilities to disclose the health information as directed below:

|  |  |  |  |
| --- | --- | --- | --- |
| **(Check one or more):** | | ❑ | Emory Johns Creek Hospital |
| ❑ | The Emory Clinic | ❑ | Emory University Hospital Midtown |
| ❑ | Emory University Hospital | ❑ | Emory University Orthopaedics and Spine Hospital |
| ❑ | Center for Rehab. Medicine | ❑ | Wesley Woods Health Center |
| ❑ | Emory Children’s Center | ❑ | Wesley Woods Geriatric Hospital |
| ❑ | Emory Specialty Associates | ❑ | Wesley Woods Outpatient Clinic |
| ❑ | Dialysis Access Center of Atlanta | ❑ | Budd Terrace |
| ❑ | Saint Joseph's Hospital of Atlanta | ❑ | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

❑ The Medical Group of Saint Joseph's, LLC

1. **Receiving Party and Method of Delivery:** qMail (Complete info below)

* Pick up (List by whom below)
* EHC Electronic Release of Information Request Website (In order to receive records via the electronic website, you must create an account through the website, then submit your request via the website. Please see attached instructions)
* Via Email (Please provide email address above)

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

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

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

Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax Number (continuing patient care support only):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Description of Health Information To Be Disclosed:**
   * Complete medical record *(Please specify dates of service)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

* + Partial Medical Record *(Please specify records below)*
  + Electronic Continuity of Care/Electronic Abstract *(please specify dates of service)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + *You must check this box if you are also requesting Billing Records*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Information | | Dates | Information | | Dates |
| ❑ | History & physical | \_\_\_\_\_\_\_ | ❑ | Office notes/Progress notes | \_\_\_\_\_\_\_ |
| ❑ | Consultations | \_\_\_\_\_\_\_ | ❑ | Operative reports | \_\_\_\_\_\_\_ |
| ❑ | Discharge summary | \_\_\_\_\_\_\_ | ❑ | Pathology reports | \_\_\_\_\_\_\_ |
| ❑ | Lab results | \_\_\_\_\_\_\_ | ❑ | Pathology slides | \_\_\_\_\_\_\_ |
| ❑ | X-rays | \_\_\_\_\_\_\_ | ❑ | EKG reports | \_\_\_\_\_\_\_ |
| ❑ | CD/Films | \_\_\_\_\_\_\_ | ❑ | Photo/Videos | \_\_\_\_\_\_\_ |
| ❑ | Cath Record | \_\_\_\_\_\_\_ | ❑ | ED Record | \_\_\_\_\_\_\_ |
| ❑ | Itemized Bill | \_\_\_\_\_\_\_ | ❑ | Rhythm Strips | \_\_\_\_\_\_\_ |
| ❑ | Other *(Please specify dates of service):*\_ | | ❑ | Pathology Slides | \_\_\_\_\_\_\_ |

1. **Purpose of Disclosure**

* At my request Need Records Certified ❑ Yes ❑ No
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

35557 **Front** NONCH35557 09/16

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(for internal purposes)*

1. **ExPiration oF autHorization**

Unless I request in writing otherwise, I understand that this authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Insert expiration date or event)*. If I do not specify an expiration date or event, this authorization will expire ninety (90)days from the date on which I signed this authorization.

1. **rigHt to rEvokE autHorization**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the Emory Healthcare facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Emory Healthcare, Inc. Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

1. **rE-disclosurE**

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.

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.

1. **rEFusal to autHorizE usE and/or disclosurE**

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Emory Healthcare may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information such research; 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).

1. **rElEasE and WaivEr**

If the health information that I have requested Emory Healthcare 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 Emory Healthcare, each of the Emory Healthcare facilities checked above, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Patient’s Representative) Date Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Description of Authority to Act for Patient

***Note: a copy of this completed, sigNed aNd dated form must be provided to the patieNt aNd/or***

***patieNt’s represeNtative aNd a copy must be placed iN the patieNt’s medical record***

**Back**

INSTRUCTIONS FOR CREATING AN ACCOUNT FOR THE EHC ELECTRONIC RELEASE OF INFORMATION REQUEST WEBSITE

If you are a walk in at one of our physical locations to request your records and you choose the electronic delivery method, please ask the receptionist for detailed instructions on how to create an account for the website.

You can also create an account for the website by going to the Emory Healthcare website at www.emoryhealthcare.org and following these steps:

Click on the “Patient & Visitor” tab.

Click on “Medical Records” on the left side of the screen.

Click on the link to create an account for the “EHC Electronic Release of Information Request Website”. Upon creating an account, you will have the ability to request your records electronically and receive them electronically.

**\*\*PLEASE NOTE: If you are requesting your records electronically from multiple Emory facilities, you must submit a separate request for each facility location. However, you only need to create an account once.**



**Release of Information Policies**

1. **To properly assist in handling your request for medical information, please completely fill out both pages of the authorization form and sign the patient fee sheet.**
2. **Provided the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, your request for information will be submitted for processing within 24 to 48 hours after receipt and delivered by mail or electronic (eDelivery) within 7 to 10 business days. If needed, the records may be picked up and you will be notified once the records are ready. This policy is nullified for medical emergencies only.**
3. **All authorizations must be dated after discharge and signed by the patient, unless he/she is a minor, deceased, physically and/or mentally impaired, or has appointed a Durable Healthcare Power of Attorney or has a court appointed guardian. Due to State and Federal laws, no exceptions will be made.**
4. **Written authorization is required.**

**Release of Information Fees for Patients**

**Delivered in electronic format via CD, Flash Drive, or Electronic Website:**

**$6.50 flat fee. Plus sales tax and actual postage if mailed.**

**Delivered in paper format:**

**$0.07 per page. Plus, if applicable: $0.90 labor cost, $0.05 per page supply cost, actual postage if mailed, and sales tax.**

**\*Please Note: If the format of the original record is Hybrid (Part electronic & Part paper), the fees will be a combination of both of the above.**

**Certification fee: $9.70**

**Radiology Film CD: $25 flat fee**

**Continued Patient Care: An Abstract of the record can be sent directly to a healthcare provider at no cost.**

**\*\*Please Note: In order to process requests for release of medical records on its behalf, Emory Healthcare has contracted with a vendor that is subject to HIPAA privacy and confidentiality requirements.**

Your questions regarding Release of Information are welcomed. Please contact the facility directly for any questions.

By signing below, I acknowledge that I have read the above procedures regarding the release of medical records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Representative Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signature



**Dear Valued Customer:**

**Thank you for allowing us the opportunity to serve your needs in obtaining your medical records.**

**In an effort to serve you better, please take a few minutes to tell us about your experience with our Release of Information services at Emory Healthcare, Inc.**

**Please go to our web page and complete our online customer satisfaction survey by doing the following:**

**Go to** www.emoryhealthcare.org

**Click on Patients & Visitors link at top of page Click on Medical Records link to the left of page**

**Click on EHC Release of Information Customer Satisfaction Survey box to the right of page.**

**Thank you for your feedback!**

**Medical Records Management**