SUMMITRIDGE HOSPITAL

Authorization for Release/Disclosure of Protected Health Information

SummitRidge Hospital
250 Scenic Hwy Lawrenceville, GA 30046
Ph # 678-442-5833 FAX # 678-442-5839

I hereby request and authorize SummitRidge Hospital to release records as described below for the purpose of:

☐ Continued Treatment ☐ Insurance ☐ Attorney ☐ Personal ☐ Other:_____

Patient's Full Name (print) _____
Date of Birth _____Medical Record #:_____
Social Security#: _____Phone#: Home _____Work_____
Current Address_____

I further request and authorize SummitRidge to release the medical/financial records checked below to:
Name: _____
Organization: _____
Address: _____

☐by Mail ☐Picked up by Person Named Above ☐by Fax (Phy. Office Only) ☐Picked up by Patient/Personal Representative
Fax #_____

☐to communicate verbally with_____☐to obtain copies from_____

This Authorization applies to the information checked below for the date(s) of service on:_____

☐ Consultation Reports	☐ History & Physical	☐ Psychiatric Evaluation	☐ Treatment Plan
☐ Discharge Summary	☐ Initial Assessments	☐ Physical/Occupational Therapy Notes	
☐ ECG/EKG reports	☐ Laboratory Test Results	☐ Progress Notes	

Please specifically describe other required Information: _____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that I may revoke this authorization at any time by presenting my revocation in writing on the SummitRidge Hospital Authorization Revocation form, except to the extent that SummitRidge Hospital has taken action in reliance on the Authorization. I further understand that this Authorization is specific to information checked above, for the date of services indicated, and for the purpose written above. I understand that this disclosure may include psychiatric, drug/alcohol, HIV testing results, AIDS related information and/or psychotherapy notes, and this information is protected under the federal regulations governing Confidentiality and Behavioral Health Patient Records, 42 CFR, Part 2, and the HIPAA Privacy Rule, 45 CRF, Parts 160 and 164. I hereby release SummitRidge from any liability which may result from furnishing the information released or requested. SummitRidge shall not condition treatment on the receipt of this authorization.

This authorization and/or request to release information from my protected health information(PHI) is fully understood and is made voluntarily on my part and includes faxing of PHI. I understand that a photo static or faxed copy of this authorization is as valid as the original.

I further understand that this authorization is valid for a period of 1 year from today's date and will expire at that time unless an earlier date is written here._____

If the patient is under the age of 18 and has had drug and/or alcohol diagnosis, treatment or education, <u>Federal Regulations</u> require us to obtain the signature of BOTH the minor and parent/guardian.

I understand there may be a copy charge and upon request, I may obtain the fee schedule

_____	_____	_____	_____
Patient Signature	**Date**	**Legal Guardian's Signature** (For Minor or Incompetent Patients)	**Date**

If signing as legal representative for the patient, signee must complete SR form 19000.

CERTIFICATION OF PATIENT'S LEGAL REPRESENTATIVE

I am not the patient. I certify that I have a legal right to obtain the medical record

of the patient _____ based on the following:
(patient's name)

- ○ **Parent. I certify that I am the parent of the patient named above, that the patient is a minor, and that my right to have access to my minor child's medical record has not been judicially terminated.**
- ○ **Legal Guardian of a Minor. I certify that I am the Legal Guardian with custody of the minor patient named above. (attach a copy of the Guardianship order)**
- ○ **Durable Power of Attorney for Healthcare. I certify that I am an Agent under a valid Durable Power of Attorney for Healthcare for the patient named above: (attach a copy of the DPOAH)**
- ○ **Guardian of the Person. I certify that the adult patient named above has been declared incompetent by a judge and that I have been appointed as Guardian of the Person. (attach a copy of the Court Order)**

_____ _____

Signature of Person Completing the Form **Date**

_____

Name of the Person Completing the Form

Dear Sir/Madam:

Your medical records will be processed once the attached authorization is completed.

Please be sure to fill out the attached authorization completely to ensure timely processing.

Note:

There may be a charge for the reproduction of your medical records.

$0.93 per page for pages 1-20
$0.80 per page for pages 21-100
$0.63 per page for pages 101 +

*The charges listed above are determined by the Georgia State Legislature and are subject to change.

Thank you.

_____

Patient

_____

Signature Date