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_____City_____State____ Zip_____

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

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

☐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._____

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.

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CERTIFICATION OF PATIENT'S LEGAL REPRESENTATIVE

_____ _____

Patient's Name Patient's Date of Birth

I, _____, the undersigned, certify that I have the authority to act on behalf of the above-named patient to request the disclosure of their medical records. Authority to act on behalf of the patient is granted to me as:

_____ Parent. 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 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 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. 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)

_____

Print Name

_____

Signature

_____

Date

ScanSTAT™ TECHNOLOGIES

Release of Information Policies

To assist in properly handling your request for health information, please **fill out the entire authorization/release form.** Incomplete forms may delay processing of your request.

Older records have been transferred to storage and will take longer to locate and copy. This information will be mailed to you at the address you indicate on the Authorization to Release Information Form. This healthcare facility maintains adult records for 10 years from the date of discharge.

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 Healthcare Power of Attorney or legal guardian. A copy of the Durable Healthcare Power of Attorney or Guardianship documentation must accompany the request.

The fee for paper copies of medical records is:

Paper Pages 1-10	$0.25 per page
Paper Pages 11+	$0.15 per page
Digital Copy	$14.85 Flat Fee

If your written request for health information has not already been filled out and submitted, please complete the authorization/release form, and have your identification and all documentation available. We are happy to assist you with any questions.

Release of Information for this healthcare facility is managed by ScanSTAT Technologies. 866-442-9026.

Please make checks or money orders payable to ScanSTAT Technologies.