SUMMITRIDGE HOSPITAL
Behavioral Health Services

Ph. 678-442-5833 Fax 678-442-5839

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Email address: Summitridgemedrecords@uhsinc.com

Patient Name: _____ *Birth Date:* _____

Maiden/Prior Names: _____ *Current Phone #:* _____

Current Address: _____ *Last 4 of SS#:* _____

To be released to or requested from:

☐ *Self (address above)*

☐ _____ (____)_____ _____

Agency/Organization *Telephone Number* *Street Address*

_____ (____)_____ _____

Name / Attention to *Fax Number* *City* *State* *Zip Code*

Via (only when released to): ☐ *Mail* ☐ *Fax* ☐ *Pick-up* ☐ *Email:* _____

☐ *Verbal Exchange of Information ONLY*

I am requesting disclosure of my protected health information for the following purpose:

☐ *Continuing Care* ☐ *Disability Determination* ☐ *Child Custody* ☐ *Personal Use*

☐ *Academic* ☐ *Legal Investigation* ☐ *Billing/Insurance* ☐ *Other:* _____

Dates of Service Requested*:* _____

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked*):*

☐ *Continuity/Transition of Care Packet*
☐ *Psychiatric Evaluation*
☐ *History and Physical*
☐ *Discharge Summary*
☐ *Progress Notes*
☐ *Physician Orders*
☐ *Lab/Diagnostic Reports*
☐ *HIV Test Results and AIDS Treatment Records*
☐ *Other:* _____

This authorization will expire on ____/____/20____. *(If not indicated, authorization will expire <u>one year</u> from signature date)*

This form must be completed in full before signing:

_____ _____ _____

Date/Time Patient's signature *Date/Time Parent/Legal Guardian signature (if applicable)* *Relationship to Patient*

_____ _____

Date/Time Signed *Witness signature/Credentials*

This authorization is intended to allow SummitRidge Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and

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interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____ _____

Date/Time *Revocation Signature*