



# NORTHSIDE HOSPITAL FORSYTH

AFFIX PATIENT LABELS OVER THIS BOX

↓ BAR CODE MUST FALL BETWEEN THESE LINES ↑

Date of Birth: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone# \_\_\_\_\_

Address: \_\_\_\_\_ Social Security # \_\_\_\_\_

Northside Hospital-Forsyth and Northside Behavioral Health Services are hereby authorized to  release  receive from:

\_\_\_\_\_  
Name or general description of Person, Agency or Institute

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

the following protected health information regarding myself/ the patient identified above:

(Please clearly specify information to be released, including dates of service if known. If information to be released includes or may include information regarding treatment or referral for treatment for substance abuse, or information which may be classified as AIDS Confidential Information under Georgia law, disclosure must be specifically authorized.) **Please note: this authorization does NOT permit release of psychotherapy notes.**

This information is requested for the purpose of: \_\_\_\_\_

This authorization for release of protected health information shall remain in effect until the earlier of \_\_\_\_\_ (specify date or termination event) or my revocation of authorization. I understand that I may revoke this authorization by submitting a written request to the Health Information Services department of Northside Hospital-Forsyth at 1200 Northside Forsyth Drive, Cumming, GA 30041. I understand that I may refuse to sign this authorization for release of information and treatment of myself /the patient at Northside Hospital-Forsyth will not be affected by my refusal.

I understand that there is a potential that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be subject to protections under the federal privacy regulations.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Patient or Legal representative

\_\_\_\_\_  
Relationship to Patient if not the Patient

\_\_\_\_\_  
Date Time AM/PM

\_\_\_\_\_  
Reason Patient unable to sign

\_\_\_\_\_  
Interpreter (if applicable)

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

### NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize redisclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse, the following notice shall also apply.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict the use of any of the information to criminally investigate or prosecute any alcohol or drug abuse patient.