ADDRESSOGRAPH

NH2493

NORTHSIDE HOSPITAL, INC.

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

ºName of Patient: _____

Patient's Date of Birth: _____

Phone #: _____

Address: _____

_____

Northside Hospital, Inc. (including Northside Hospital-Atlanta, Northside Hospital-Forsyth, Northside Hospital-Cherokee, Northside Hospital Behavioral Health Services, and other healthcare facilities owned and/or operated by Northside Hospital, Inc.) is hereby authorized to **(Please mark appropriate box):**

☐ **Release to** <u>**OR**</u> ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) **(Please identify by name or general description and provide address, if known):** _____

_____

_____

The following protected health information regarding the patient **(Please mark appropriate box(es))**: ☐ Complete Medical Record
☐ Abstract of Medical Record (physician dictated reports & diagnostic reports) ☐ Labs only ☐ Radiology only ☐EKG only
☐ Other **(Please specify clearly)** _____
For the following dates of service: _____

<u>**Unless you state otherwise**</u>, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse**, **including drugs and alcohol**, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a separate consent form is required.

<u>**Unless you state otherwise by marking one or both boxes below**</u>, this authorization **includes** the release and disclosure of records and information which may include (i) **"HIV/AIDS confidential information"** and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider and **you affirmatively waive any protections from disclosure** that might otherwise apply. HIV/AIDS Confidential Information is defined by Georgia law to include the fact that a patient has had an HIV test or has been counseled about HIV, even if the test is negative. **Note:** Unless otherwise permitted by law, the release of **"HIV/AIDS confidential information"** and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I <u>**object**</u> to the release of "HIV/AIDS confidential information".
☐ I <u>**object**</u> to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is **(Please describe each purpose of the requested use or disclosure):**_____

_____

_____

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:
(a) _____**(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit,**); (b) the date I revoke this authorization in writing; or (c) three (3) years from the date I sign this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries, or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient <u>OR</u> (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____
Witness

_____ AM/PM_____
Date Time

_____
Interpreter (if applicable)
Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

_____
Signature of Patient or Legally Authorized Representative, including Legal Guardian, Health Care Agent, or Parent of Minor Child

Print name:_____

Relationship to patient:_____

Reason patient unable to sign:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Original - Medical Records
Yellow Copy - Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

I understand that treatment of the patient (either myself or the patient named above) at Northside Hospital will not be affected if I refuse to sign this authorization. I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage.

Note: This authorization can be revoked by submitting a written request to the Health Information Services Department of Northside Hospital at 1000 Johnson Ferry Road, Atlanta, Georgia, 30342.

Note: To authorize the disclosure of psychotherapy notes, the additional form entitled ***Authorization for Release of Psychotherapy Notes*** will need to be completed. To authorize the disclosure of patient records from the Northside Hospital Behavioral Health Recovery Program, the additional form entitled ***Authorization for Release of Alcohol and Drug Abuse Patient Records*** will need to be completed.

I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided (including, but not limited to, electronic transmission, paper copies, CDs, films, and flash drives) may be subject to re-disclosure by the recipient and will no longer be subject to protections under the federal privacy laws and regulations. I hereby release the Northside Hospital, Inc. and its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of these medical records and the information included I have authorized above.

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 re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse which is protected by Federal confidentiality rules (42 C.F.R. Part 2), the following notice shall also apply.

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