WOMEN'S
Medical Center

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient name:_____ Last 4 digits of SSN:_____
Previous name, if applicable:_____
Address:_____ City:_____ State:_____ Zip Code:_____
Date of birth:___/___/_____ Home phone:_____ Work phone:_____
Email address:_____

1. **The following organization has my authorization to disclose my individual health information (FROM)**:

Name, Address, Phone, Fax: _____

I would like for my individual health information to go to the following organization (TO):

Name, Address, Phone, Fax: _____

2. **Method of Delivery:**
   - Mail
   - Pick Up
   - Fax to phone number: _____

3. **Description of Health Information to be Disclosed:**

- Complete medical record (please specify dates of service): _____
  OR
- Partial medical record (please specify records below)
- Electronic continuity of care/Electronic Abstract (please specify dates of service): _____
- You must check this box if you are also requesting billing records

4. **Information**	**Dates**
○ History & Physical	_____
○ Consultations	_____
○ Discharge summary	_____
○ Lab results	_____
○ X-Rays	_____
○ CD/films	_____
○ Itemized bill	_____
○ Office notes/Progress notes	_____
○ Operative reports	_____
○ Photos/videos	_____

- Other (Please specify) _____

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5. **Purpose of Disclosure:**
   - ○ At my request
   - ○ Continuation of care
   - ○ Other: _____

6. **Expiration of Authorization**
   Unless I request in writing otherwise, I understand this authorization will expire on _____ (Insert expiration date or event). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I sign the authorization.
7. **Right to Revoke Authorization**
   I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department of Women's Medical Center. An address for the Medical Records department is 190 Handley Drive, Suite A, Tyrone, GA 30290. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.
8. **Re-Disclosure**
   I understand that if my health information is disclosed to a party other than a health care provider, health plan, or heath care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.
9. **Fees**
   I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.
10. **Release and Waiver**
    If the health information I have requested Women's Medical Center to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), immunodeficiency syndrome related complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for this purpose(s) of releasing it to the party or parties authorized above. I also release Women's Medical Center, their officers, trustees, agents, and employees, from any and all liabilities, damages and claims, which might arise from the release of health information authorized by me.

_____ _____ _____

Signature of Patient (or Patient's Representative) Date Time

_____ _____

Printed Name Description of Authority to Act for Patient

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Release of Information Fees

1. To properly assist in handling your request for medical information, please completely fill out both pages of the authorization form and sign the patient fee sheet.
2. You request for information will be submitted for processing and ready within 7 to 10 business days. If needed, the records may be picked up and you will be notified when the records are ready. This is nullified for medical emergencies only.
3. All authorizations must be dated and signed by the patient, unless he/she is a minor, deceased, physically and/or mentally impaired, or has appointed a Durable Healthcare Power of Attorney or has a court appointed guardian. Due to state and federal laws, no exceptions will be made.
4. Written authorization is required.
5. Fees only apply if you want a personal copy of your medical records. There is no fee to send records to another healthcare provider.

Release of Information Fee for Patients

Copy Cost:

1-20 pages $.97/page

21-100 pages $.83/page

100 or more pages $.66/page

There is a $10 minimum

Your questions regarding Release of Information are welcomed. Please contact facility directly for any questions at 770-997-5714.

By signing below, I acknowledge that I have read the above procedures regarding release the of medical records.

_____ _____

Patient/Representative Signature Date

_____

Printed Name of Patient