Wellstar Health System

For Internal Purposes
Account Number: _____
Medical Record Number: _____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name, if applicable: _____ Last 4 digits of Social Security #: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Home / Cell Phone: _____ Work Phone: _____

1. WELLSTAR HEALTH SYSTEM:
I authorize representatives from the following facility / facilities to disclose the above-named individual's health information as directed below (check one or more):

- ❒ Atlanta Medical Center Downtown
- ❒ Atlanta Medical Center South
- ❒ Cobb Hospital
- ❒ Douglas Hospital
- ❒ North Fulton Hospital
- ❒ Kennestone Regional Medical Center
- ❒ Paulding Hospital
- ❒ Spalding Regional Hospital
- ❒ Sylvan Grove Hospital
- ❒ West Georgia Medical Center
- ❒ Windy Hill Hospital
- ❒ All Locations
- ❒ Wellstar Medical Group - Practice Name: _____ Practice Location: _____

2. RELEASE INSTRUCTIONS:

❒ Please send my record via MyChart (at no cost).
You must have an active MyChart account. If you don't have an active account, go to this website to activate: mychart.wellstar.org and click on Sign Up (I don't have a code). You may call the MyChart support desk at 470-644-0419 with any questions.

Records are available in MyChart if you were seen at these locations or the affiliated Wellstar Medical Group practices:
-- From December 2013 to present at Kennestone Regional Medical Center
-- From April 2014 to present at these hospitals: Cobb, Douglas, Paulding and Windy Hill
-- From March 2018 to present at these hospitals: Atlanta Medical Center Downtown and South, North Fulton, Spalding, Sylvan Grove and West Georgia

❒ Please send my record via eDelivery. My email address is: _____
You will receive an email with instructions on how to access your records.

❒ Please fax my health information to my healthcare provider. Fax number: _____
Faxing is restricted to continuity of care requests only.

❒ I would like to pick up my health information in person. If someone other than yourself will be picking it up, please provide their name: _____

❒ Please send my health information by mail to:

Name: _____

Street Address: _____

City, State. ZIP: _____

3. PURPOSE OF DISCLOSURE:

- ❒ Personal Use
- ❒ Insurance
- ❒ Disability
- ❒ Attorney / Legal
- ❒ Continuity of Care
- ❒ Other: _____

4. EXPIRATION OF AUTHORIZATION:
Unless I request in writing otherwise, this authorization will expire on _____ (insert 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 it was signed.

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5. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

❒ Complete medical record / health information (please specify dates of service): _____

❒ Abstract of my health information (information needed for continuity of care: includes physician notes, emergency room records, test results, radiology reports)

❒ Partial medical record (please specify records below):

Information	Dates of Service	Information	Dates of Service
❒ History and Physical	_____	❒ Office Notes	_____
❒ Consultations	_____	❒ Operative Report	_____
❒ Discharge Summary	_____	❒ Pathology Report	_____
❒ Lab Results	_____	❒ Cardiology / EKG Reports	_____
❒ Radiology report only	_____	❒ Emergency Room Record	_____
❒ Radiology images on a CD	_____	❒ Billing records	_____

❒ All: _____ Please specify dates of service: _____

6. 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 written revocation to the Health Information Management Department(s) of the Wellstar Health System facility or facilities checked above. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. 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. The fee schedule may be viewed at dch.georgia.gov/medical-records-retrieval-rates.

8. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE:
I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment. However, if I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Wellstar Health System may decline to treat me if I refuse to sign this information only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a pre-employment drug screen).

9. RE-DISCLOSURE:
I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare 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.

10. RELEASE AND WAIVER:
If the health information that I have requested Wellstar Health System 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 the purpose(s) of releasing it to the party or parties authorized above.

I also release Wellstar Health System, each of the Wellstar Health System facilities checked above and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

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

_____
Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.