WELLSTAR Medical Group

Patient Authorization for Use and Disclosure of Protected Health Information

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly)*:

_____ _____ _____ _____

Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____ _____

Street Address *Apt. #/P.O. Box # (Please include complete mailing address)* *Medical Record #/Social Security# (optional)*

_____ _____ _____ _____

City *State* *Zip Code* *Primary Contact Number*

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

_____ _____ _____

Business Number *Cell Phone Number* *Other Phone Number*

I authorize the WellStar Medical Group to disclose Protected Health Information to the following persons:

☐ Spouse: _____ _____

Name *Phone Number*

☐ Child(ren): _____ _____

Name *Phone Number*

_____ _____

Name *Phone Number*

☐ Other: _____ _____

Name *Phone Number*

Information to be disclosed

☐ All Medical Information ☐ Laboratory Results ☐ All Billing/Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature/Date: *(date authorization signed by patient or Legal Guardian/Personal Representative)* _____

Month/Day/Year

_____ _____

Print Patient Name or Name of Legal Guardian/Personal Representative *Signature of Patient or Legal Guardian/Personal Representative*

_____

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

WELLSTAR Medical Group

Acknowledgment of Receipt of "Notice of Privacy Practices" for Protected Health Information

I acknowledge that I have received a copy of WellStar Health System's "Notice of Privacy Practices" for protected health information on the date set forth below.

_____
Date of Receipt

Patient Information *(please print clearly)*:

_____ _____
Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____ _____
Print Patient Name or Legal Guardian/Personal Representative *Relationship to Patient*

_____
Signature of Patient or Legal Guardian/Personal Representative

Release and Assignment:

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform the WellStar Medical Group of any changes in my address, phone number or insurance. I understand that I am financially responsible for any amounts not covered by my insurance. _____

For use by WellStar Personnel Only *(complete this section if patient acknowledgement is **not** received)*:

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication/language or other barrier
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other: *Please indicate reason* _____

Signature of WellStar Representative: _____ Date: _____

Last Name: _____ **First Name:** _____ **DOB:** _____

E-Mail Address: _____

It is the goal of WellStar East Paulding Primary Care Center to provide excellent healthcare with both respect for your privacy and your time. During office visits, it may be necessary to have lab work or other diagnostic tests performed either in our office or at an outside facility. If our provider feels that your results warrant further explanation and we are unable to contact you, we must have an alternate means of contacting you. In compliance with HIPAA laws, our office may only divulge the results of any test(s) to the patient, or parent/guardian of a minor under the age of 18, unless you, "the patient" specify otherwise.

Please indicate below the method in which you prefer to be contacted:

Letter sent to your home address: _____

Call my home number: (_____) _____

Call my cell number: (_____) _____

Call my work number: (_____) _____

ALL OF THE ABOVE

If granting permission for our office to contact you by phone, may we leave a detailed message on your voicemail and/or answering machine, regarding any test(s) results and/or account information?

Yes No

May our office speak with anyone else other than you (i.e. spouse, adult children, etc) regarding results, prescriptions, billing, referrals or any other healthcare related information?

Yes No

If permissible, please list those who we may speak with on your behalf:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Guardian Signature: _____ **Date:** _____