NH2493

NORTHSIDE HOSPITAL

English - Spanish - Korean

Patient (Full) Name: _____ Date of Birth: _____

Previous Name, if applicable: _____ Preferred Phone #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

1. **FACILITY(IES) AUTHORIZED TO RELEASE MY HEALTH INFORMATION:**
I hereby authorize Northside to disclose my health information from the following facility(ies) and/or practices as directed below ***(check one or more)***:

- ☐ Northside Hospital Atlanta
- ☐ Northside Hospital Cherokee
- ☐ Northside Hospital Duluth
- ☐ Northside Hospital Behavioral Health Services
- ☐ Northside Hospital Forsyth
- ☐ Northside Hospital Gwinnett
- ☐ All Northside Campuses
- ☐ Northside Affiliated Practice (specify name of practice): _____

I understand that my medical record may also include health information from other healthcare providers involved in my care.

2. **TO WHOM MY HEALTH INFORMATION MAYBE DISCLOSED TO OR RECEIVED FROM:**
I authorize that the health information described below in this form to be disclosed to or received from the following entity(ies) / individual(s) ***(check the box that applies)*** ☐ **disclose to** ☐ **receive from**

Name of Person/Organization/Clinic: _____
Address: _____ City: _____
State: _____ Zip: _____
Telephone: _____ FAX: _____
Email Address: _____

3. **RELEASE INSTRUCTIONS:**
- ☐ Email (Email Address): _____
- ☐ 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: _____
- ☐ US Mail via the address listed above.
- ☐ CD
- ☐ Please FAX to my healthcare provider (listed in Section #2). *Faxing is restricted to continuity of care requests only.*

Need records certified: ☐ YES ☐ NO

4. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**
DATES OF SERVICE: **From:** _____ **To:** _____

- ☐ Complete medical record
- ☐ Abstract/Continuity of Care
- ☐ Billing Records
- ☐ All Imaging Records

Partial medical record (Please specify records by checking all that apply below)

- ☐ Physician Office Notes
- ☐ Consultations
- ☐ Operative/Procedure Reports
- ☐ Lab Results
- ☐ Emergency Room Dept. Reports
- ☐ Progress Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Cardiology/EKG Reports
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Pathology Reports
- ☐ Other (please specify): _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

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5. **PURPOSE OF DISCLOSURE:**

☐ Personal Use ☐ Attorney / Legal ☐ Continuity of Care- Medical Treatment ☐ Insurance
☐ Disability ☐ Other (describe): _____

6. **EXPIRATION OF AUTHORIZATION:** I understand that this authorization will expire 6 months from the date of signature unless an alternative date is inserted here: _____.

7. **REVOCATION:** I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it. 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.

8. **FEES:** I understand that federal and state laws allow for certain reasonable, cost-based fees to be charged for the copying and provision of patient records. If fees apply to my request, I will be responsible for payment of these fees.

9. **RE-DISCLOSURE:** I understand the potential that medical records and information which are disclosed pursuant to this authorization in whatever form and/or means provided 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 further understand that any electronic format of my health information may not be encrypted or password protected and I am responsible for taking precautions to protect the data and storing it in a secure manner. I hereby release Northside 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 therein

10. **REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE:** I understand that authorizing the use or disclosure of the information above is voluntary and that Northside may not condition treatment upon my signing of this authorization, except in limited circumstances in which (1) such conditioning is permitted for research-related treatment, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers' compensation examination).

11. **WAIVER:** If the health information I have requested Northside to disclose includes any information related to mental health, substance abuse, testing/treatment of infectious diseases (including without limitation HIV/AIDS confidential information, venereal disease, tuberculosis, or hepatitis) or genetic testing, I consent to the disclosure of such sensitive health information by Northside and waive any privilege regarding such information for the purpose of releasing it to the parties authorized above. If I am a birth mother signing this authorization on behalf of my minor child, I acknowledge that the minor's records may also include my sensitive health information related to mental health, substance abuse, infectious disease (including without limitation HIV/AIDS confidential information, venereal disease, tuberculosis, or hepatitis) or genetic testing, and I hereby consent to the disclosure of my sensitive health information in my minor child's record and waive any privilege concerning such information for the purpose of releasing it to the party(ies) authorized above.

Note: Please read this form in entirety and complete all applicable lines below with your signature and date. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) you are legally authorized to have access to the patient's medical records. *You may be asked for additional documentation.*

_____ _____
Signature of Patient or Legal Representative Date Reason Patient Unable to Sign

_____
Relationship to Patient If Not the Patient

_____
Interpreter's Signature Date/Time
Note: If remote interpretation used (phone/iPad), record interpreter name, ID#
Interpreter Comments (optional):_____

_____

NOTICE TO PARTY RECEIVING SUBSTANCE ABUSE RECORDS: 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

Please return completed form via email to roirequest@northside.com or via fax to 404-250-8248.