**HCA PHYSICIAN SERVICES – GEORGIA CENTER FOR PELVIC HEALTH**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Original – Practice HIM.PRI.001, PS 70-190 Authorizations

Copy – Patient

Copy – Recipient

**Revision Date:** April 15, 2005

**Section A:**

**Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient?** If yes, complete the Authorization for Research Form. If no, proceed to Section B.

**Section B:**

**Required for all Authorizations for Release of PHI or Right to Access**

Patient Name: Birth Date:

Social Security No. *(optional)*: Patient’s Address:

Requestor’s Name Phone Number (if patient is not the requestor):

PHI Recipient Name:

Address/City/State/Zip Phone Number: (\_\_) \_\_\_\_\_\_\_\_

Fax Number: (\_\_) \_\_\_\_\_\_\_\_ PHI Sender Name:

Address/City/State/Zip Phone Number: (\_\_) \_\_\_\_\_\_\_\_

Fax Number: (\_\_) \_\_\_\_\_\_\_\_

This authorization will expire on the following: (Fill in the Date or the Event, but not both

Date: Event: .) Purpose of Disclosure:

Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this

No, then you may check as many items below as you need. authorization.

Description: Date(s)

Description: Date(s)

Description: Date(s)

All PHI in record History and Physical

Consult Report Operative Report

Progress Notes Physician Orders

Laboratory Imaging/Radiology

Nursing Notes Medication Record

Demographics Rehabilitation Services

Special Test/Therapy Itemized Bill/Claims

Other:

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Initial) If not, applicable, check here

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).

2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.

5. I will receive a copy of this form after I sign it.

**Section C: Signatures**

**I have read the above and authorize the disclosure of the protected health information as stated.**

Signature of Patient/Guardian/Patient Representative:

Date:

Print Name of Patient’s Representative:

Relationship to Patient:

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