LAUREATE MEDICAL GROUP
Medical Excellence. Compassionate Care.
An Affiliate of Northside Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

Laureate Medical Group identified above is hereby authorized to **(Please mark appropriate box)**:

☐ **Release to OR** ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) (**Please identify by name or facility and indicate address or fax to send to**): _____

Address: _____

Fax: _____

The following protected health information regarding the patient **(Please mark appropriate box(es))**:

☐ Complete Medical Record ☐ Abstract of Medical Record (physician dictated reports & diagnostic reports)

☐ Labs only ☐ Radiology only ☐EKG only

☐ Other (**Please specify clearly**) _____ For the following dates of service: _____

Unless you state otherwise, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse**, **including drugs and alcohol,** except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

Unless you state otherwise by marking one or both boxes below, this authorization **includes** the release and disclosure of records and information which may include (i) **HIV/AIDS** confidential information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and **you affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/ AIDS confidential information** is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** confidential information and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I **object** to the release of **HIV/AIDS** confidential information.

☐ I **object** to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is (**Please describe each purpose of the requested use or disclosure**):

_____

_____

3400C Old Milton Pkwy, Suite 500 Alpharetta, GA 30005 678-775-2284 Fax: 678-775-2285

460 Northside Cherokee Blvd, Suite 170, Canton, GA 30115 678-538-2167 Fax: 678-538-2165

4800 Olde Towne Parkway, Suite 400 Marietta, GA 30068 678-718-2940 Fax: 678-718-2941

7823 Spivey Station Blvd, Suite 310 Jonesboro, GA 30236 770-996-1122 Fax: 770-907-1429

550 Peachtree St, NE Suite 1550 Atlanta, Georgia 30308 404-892-2131 Fax: 404-215-9222

6135 Barfield Road Suite 200 Atlanta, Georgia 30328 404-256-8500 Fax: 404-256-8506

684 Sixes Road Suite 265 Holly Springs, GA 30115 770-720-2221 Fax: 770-720-2282

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This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:(a) _____(**in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit)**; (b) the date I revoke this authorization in writing; or (c) three (3) years from the date on which I signed this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____
Signature of Patient or Legally Authorized Representative, including Legal Guardian, Health Care Agent, or Parent of Minor Child

Print Name:_____

Relationship to Patient:_____

Reason Unable to Sign:_____

_____ AM/PM _____
Date Time

_____
Interpreter (if applicable)

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

This authorization can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified on the front of this form. I understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. I also understand that treatment of the patient (either myself or the patient named above) at the Northside Hospital Physician Office Practice and/or Northside Hospital will not be affected if I refuse to sign this authorization.
Note: To authorize the disclosure of psychotherapy notes, the additional form entitled ***Authorization for Release of Psychotherapy Notes*** will need to be completed. To authorize the disclosure of patient records from the Northside Hospital Behavioral Health Recovery Program, the additional form entitled ***Authorization for Release of Alcohol and Drug Abuse Patient Records*** will need to be completed. I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided (including, but not limited to, electronic transmission, paper copies, CDs, films, and flash drives) may be subject to re-disclosure by the recipient and may no longer be subject to protections under the federal privacy laws and regulations. I hereby release the Northside Hospital Physician Office Practice, Northside Hospital, Inc., and their agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of the medical records and information I have authorized above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse which is protected by Federal confidentiality rules (42 C.F.R. Part 2), the following notice shall also apply.
This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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