A Northside Network Provider

English - Spanish

Name of Patient: _____ Phone #: _____ DOB: _____

Address: _____

Physician Practice Name: _____

The Northside Hospital Office Practice 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 general description and provide address, if known**): _____
_____

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: Start Date: _____ End Date: _____
In the following format: ☐ Paper ☐ Electronic **Need records certified:** ☐ Yes ☐ No
I understand that in some instances my medical record may also include my health information from other healthcare facilities owned and/or operated by Northside Hospital.

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: _____
I understand that my/ the patient's treatment at a Northside Hospital Physician Practice Office and/or Northside Hospital will not be affected if I refuse to sign this authorization. I also 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. **Note:** This authorization can be revoked by submitting a written request to the **Practice Coordinator at the Northside Hospital Physician Practice Office identified above**.

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.

_____
Witness Date/Time

_____
Interpreter Signature Date/Time
Note: If phone/video interpretation used, record interpreter ID#
Interpreter comments (optional): _____
_____

_____
Signature of Patient or Legal Representative Date/Time

_____
Relationship to Patient If Not the Patient

_____
Reason Patient Unable to Sign

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

White - Medical Records
Yellow - Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

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 further understand that any electronic format of my health information that I receive 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. By choosing to receive my health information electronically, I acknowledge and accept the risk of doing so. 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.**