Starr's Mill Internal Medicine

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize (print name of hospital/physician) ____ to:
(initial **one** or **more** choices below as desired)

_____ Provide **copies** of my records checked below to:
Name (receiving person/party) **___Starr's Mill Internal Medicine___________________________________**
Address **_1330 Highway 74, South, Fayetteville, GA 30215___________________________________**
Fax # **__(770) 631-2503__________________________** Phone # **__(770) 631-2502______________________**

_____ Permit **review** of my records checked below by (name)____

_____ Permit (person's name)______________________to be **present** during my □ consultation □ exam □ procedure
(check appropriate box above)

_____ Use/disclose PHI as directed: ____

This authorization applies to records or PHI access from the following date or dates of service: ____________________

The information used/disclosed pursuant to the authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but **may include** other detailed mental health information, HIV/AIDS information regarding alcohol or substance abuse.

- □ **Entire Medical Record***
- □ **Abstract of Record****
- □ **Financial Record**
- □ **Pathology Slides/Blocks**
- □ **Radiology Films**
- □ Ambulance Record
- □ Autopsy Report
- □ Cardiac Cath Report
- □ Consent Forms
- □ Consultation Reports
- □ Discharge Summary Reports
- □ Doctors Orders
- □ ECG/EKG Reports
- □ Emergency Room Records
- □ Face Sheet
- □ Gastro Intestinal Lab Reports
- □ History and Physical Reports
- □ Laboratory Test Results
- □ Medication Records
- □ Neurodiagnostic Reports
- □ Operative Reports
- □ Pathology Reports
- □ Physical/Occupational therapy Notes
- □ Radiology Reports
- □ Speech-Language Pathology Reports
- □ Treatment Plan
- □ **Diagnostic Photos – Specify_______**
- □ **Other – Specify_________________**
- □ **Notes –Specify__________________**

* Entire Medical Record includes all items NOT in bold print.
** An abstract of the record includes the History/Physical Report , Operative, Consultation and Discharge Summary Reports, and Diagnostic test results.

Purpose of Use or Disclosure: □ At the request of the individual (patient)
□ Other____

The following information is needed to assist the provider in locating the patient's record:

Patient's Full Name: ____Patient's SSN: ________________________________

Maiden/Other Name: ____Patient's Date of Birth: _________________________________

Patient's Phone # (Home) ______________________________ (Work) ____________________________ (Cell) ________________________

Current Address: ____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on the Authorization. A revocation form may be obtained from the Medical Records Department. The completed revocation must be presented to the Medical Records Department. I further understand that this Authorization is specific to the information checked above, for the dates of service indicated, and for the purpose written above. Providers shall not condition treatment on the receipt of the Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness0for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here____.**

____	____	______________________
Patient's or Legal Representative's Signature	**Please Print Name**	**Today's Date**

As Legal Representative, my relationship to the patient is____. Any document proving such authority must be attached. The patient is unable to sign because ____.

NOTE: There may be fees for provision of any or all requested information. Under most circumstances, the law permits up to 30 days for record requests to be processed, however records for treatment purposes can be immediately faxed to the patient's healthcare provider when requested.