Authorization for Disclosure of Health Information

PATIENT INFORMATION:

Print Name: _____ Previous (If Applicable):_____

Date of Birth: _____ MRN (if known): _____

Address: _____ Apt/Unit: _____

City: _____ State:_____ Zip Code: _____

Phone Number: _____ Email Address: _____

I authorize the release of health information of the above-named patient from:

☐Shepherd Center ☐Other Facility: _____

Other Facility Address: _____

Phone: _____ Fax: _____

PURPOSE OF RELEASE: ☐Continuity of Care ☐ Legal ☐Insurance ☐ Personal

☐Other: _____

RECIPIENT OF INFORMATION:

Please specify the one (1) person or facility you authorize to receive your health information:

Person/Facility: _____

Address: _____

City:_____State: _____ Zip Code: _____

Fax (Continuity of Care Only): _____ Phone:_____

Release format: ☐ Email ☐ CD ☐ Paper

DESCRIPTION OF INFORMATION TO BE RELEASED:

Dates of Service requested: _____to_____

Hospital Visits (and/or) Outpatient Visits	Diagnostic Reports	Radiology Imaging
❑ Discharge Summary ❑ History and Physical ❑ Physicians Orders ❑ Progress Notes ❑ Consultations ❑ Itemized Bills ❑ Therapy Evaluations-PT/OT/ST ❑ Therapy Notes – PT/OT/ST ❑ Driving Evaluation ❑ Wheelchair Evaluation Other: _____	❑ Radiology Reports ❑ Laboratory Reports ❑ EKG/ECG Reports ❑ Barium Swallow Report Other: _____	(Released on CD) ❑ All imaging ❑ MRI ❑ CT ❑ Xray ❑ Ultrasound Other:_____

- ❑ Abstract (Discharge Summary, History and Physical, Therapy Evaluation Note, Consultations, Diagnostic Results and Labs)
- ❑ Entire Medical Record **with** Nurse's Notes (excludes Radiology CD and Billing)
- ❑ Entire Medical Record **without** Nurse's Notes (excludes Radiology CD and Billing)

Other: _____

Special Categories of Records: Certain records related to substance use disorders, mental health, and HIV/AIDS information have special protections and require you to specify if the information is to be included in this disclosure.

- ❑ Neuropsychology Report
- ❑ Psychotherapy Notes*
- ❑ Substance Use Disorder Records
- ❑ HIV/AIDS Information
- ❑ Other: _____

***A separate authorization is required for psychotherapy notes and cannot be combined with a request for other types of records.**

Signature: _____ Date_____

By signing this Authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- Except to the extent that Shepherd Center or another lawful holder of the information has already relied on this authorization, I understand that I have the right to revoke this authorization at any time by sending a written notice to Shepherd Center, Health Information Management Department, at the address noted below.
- This authorization will expire (please select **one** option below):
  - ❑ Once fulfilled.
  - ❑ Within _____ days of the dated signature.
  - ❑ At the end of my treatment relationship with Shepherd Center.
  - ❑ Other: _____
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the disclosed information may not be protected by federal confidentiality rules.
- Shepherd Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

_____ _____

Patient **OR** Authorized Representative*** Signature Printed Name

_____ _____

Relationship to Patient (if applicable) Date

***If signed by an Authorized Representative, please indicate your relationship to the patient.

- If you have formal legal authority (e.g., Healthcare Power of Attorney, Guardianship/Conservatorship, Executorship), please provide a copy of that documentation.
- If not, please describe how you are acting as the patient's authorized representative (e.g., spouse, parent, adult child, legal next of kin).
- If the patient is deceased, please provide Letters of Executorship.
- If a workers' compensation attorney is requesting records, please provide a GA WC207 or similar workers' compensation authorization form from another state.

SUBMIT AUTHORIZATION: Email: roi@shepherd.org OR **Fax:** 404-350-7772 OR **Mail** (see address below)