



DT0013

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Return To: _____

Athens Regional Health Services, Inc.
d/b/a Athens Regional Health System ("ARHS")
1199 Prince Avenue
Athens, Georgia 30606

PATIENT INFORMATION:

Name			Date of Birth			Social Security Number		
Street Address						City, State, Zip Code		
Phone Number			FOR INTERNAL USE ONLY:					
Medical Record Number						Patient's Account Number		

I HEREBY AUTHORIZE ARHS TO: (Check one below)

_____ RELEASE INFORMATION TO:	_____ OBTAIN INFORMATION FROM:
(Attorney/Physician/Institution/Agency/Individual)	
_____ (Street Address)	_____ (City, State, Zip Code)
_____ (Telephone Number)	_____ (Fax Number)
_____ (Date(s) of Treatment)	

PLEASE INDICATE DELIVERY METHOD: Will Pick Up Mail to Address Above

FOR THE PURPOSE OF: Healthcare Facility Insurance Legal Permanent Release

Personal Physician Disability Pre-Surgical Evaluation

Other (Please specify): _____



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Unless indicated by specific request checked below, I permit the release of any and all information including, if any, information concerning drug/alcohol abuse records, venereal disease and other statutorily protected diseases, psychiatric records (excluding psychotherapy notes), or AIDS/HIV testing treatment records.

Please Check Specific Information Requested for Release:

All PHI in medical record ER Report(s) Discharge Summary
 Operative Report History and Physical Pathology Report(s)
 Progress/Office Note(s) Laboratory Report(s) Radiology Report(s)
 Other (Please Specify) _____ Images
 *Psychotherapy Note(s) Cardiac Records

***PATIENT INITIALS: _____ *If this is a request for psychotherapy notes, I authorize these records to be released along with the other requested information.**

I understand that:

- I may revoke this authorization at any time in writing and present my written revocation to the ARHS facility.
- The revocation will not apply to information that has already been released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I may refuse to sign this authorization.
- Disclosure of health information is voluntary.
- I need not sign this authorization to ensure treatment nor will it affect my payment status.
- Any disclosure of information carries with it the potential for an unauthorized redisclosure.
- I may inspect or have a copy of the information described on this form if I ask for it.
- I get a copy of this form after I sign it.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days.

AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE.

If I have questions about the disclosure of my protected health information, I can contact the Health Information Management Department or the Compliance Department. I have read the above and authorize the disclosure of the protected health information as stated.

(Signature of Patient or Legal Representative)

(Date/Time of Signature)

If signed by legal representative, relationship of individual to patient: _____

(Signature of Witness)

(Date/Time of Signature)

(Witness Street Address)

(Witness Phone Number)

(City, State, Zip Code)