3995 SOUTH COBB DRIVE/SMYRNA, GEORGIA 30080
PHONE 770-434-4567 / FAX 770-431-7043

AUTHORIZATION TO RELEASE INFORMATION - (MUST BE COMPLETED IN FULL)

Patient Name: _____

Birth Date: _____ Social Security Number: _____

I HEREBY REQUEST AND AUTHORIZE RIDGEVIEW INSTITUTE:

CHECK ALL THAT APPLY: [ ] TO RELEASE TO: (COPYING CHARGES MAY APPLY) [ ] TO REQUEST FROM:

_____
(NAME)

_____
(ADDRESS)

_____(PHONE)_____
(CITY/STATE/ZIP)

(FAX)_____

THE FOLLOWING INFORMATION:
CHECK APPROPRIATE AREAS TO BE RELEASED - YOU MUST BE SPECIFIC.

[ ] FACE SHEET
[ ] DISCHARGE SUMMARY
[ ] HISTORY & PHYSICAL
[ ] PSYCHIATRIC EVALUATION (DATA BASE)
[ ] PSYCHOLOGICAL EVALUATION
[ ] INITIAL CLINICAL ASSESSMENT
[ ] CONTINUING CARE PLAN
[ ] PSYCHOSOCIAL HISTORY
[ ] TREATMENT PLAN
[ ] TELEPHONE CALLS/VERBAL COMMUNICATION
[ ] LABORATORY /RADIOLOGY REPORTS
[ ] DISCHARGE PLAN FORM
[ ] CONSULTATIONS
[ ] ABSTRACT OF RECORD ONLY (ABSTRACT CONSISTS OF PSYCH EVALUATION, HISTORY & PHYSICAL, DISCHARGE SUMMARY, PSYCHOLOGICAL EVALUATION. COPYING CHARGES DO NOT APPLY)
[ ] OTHER (PLEASE SPECIFY): _____

FOR THE PURPOSE OF: (MUST BE COMPLETED) ( ) CONTINUED TREATMENT ( ) OTHER _____

I understand authorizing the use or disclosure of the health information identified above is voluntary and I need not sign this authorization form to ensure healthcare treatment.

I understand that any disclosure of private health information carries the potential for unauthorized re-disclosure and may no longer be protected by federal privacy laws or regulations. I further agree to indemnify and hold harmless Ridgeview's staff from all liability that may arise from the release of the information herein requested.

I understand that I have the right to inspect or obtain a copy of the health information to be disclosed. Medical records frequently contain information which may be privileged and/or confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of the privileged/confidential information will be harmful to the patient, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, patient photographs, AIDS/HIV or psychiatric/psychological/other mental health privileged or confidential information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After giving due consideration to the above statement, I authorize the hospital and/or members of its staff to furnish information, including electronic, photostatic or faxed copies of my medical record, including matters privileged under the laws of the state of Georgia, and applicable Federal laws and regulations including but not limited to the Health Insurance Portability And Accountability Act (HIPAA), to the above organization/Individual, or to its agents.

I understand that I have the right to revoke this authorization at any time and that revocation request must be submitted in writing. I understand the revocation will not apply to information that has previously been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked this authorization is only valid for a period of one (1) year from the date of my signature, unless I specify another date or event here: _____.

_____ _____
DATE/TIME SIGNED PATIENT SIGNATURE

_____ _____
WITNESS SIGNATURE (LEGAL GUARDIAN SIGNATURE IF APPLICABLE) RELATIONSHIP

Prohibition on redisclosure: this information may be protected by Federal Regulation (42 CFR Part 2) which prohibits you from making further disclosure.