RI0040

AUTHORIZATION
FOR
DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Phone Number: _____

I hereby authorize Hamilton Medical Center, Inc. together with its covered entity Affiliates and their employees, agents, medical staff and contractors (collectively "Hamilton"), to use or disclose the Patient's protected health information ("PHI") covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as specified in this Authorization. I understand that this Authorization is for use by Hamilton Medical Center and also Hamilton Medical Center's covered entity Affiliates.

I understand that PHI includes records disclosed to Hamilton by health care providers and facilities who previously provided treatment to the Patient. I also understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment, substance abuse treatment, privileged communications, genetic information, infectious or communicable diseases, or information relating to testing or treatment for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus).

Information to be Used or Disclosed:

- ❑ Complete Medical Record, excluding all images

OR

The following selected items (check all that apply):

- ❑ Discharge Summary
- ❑ History and Physical Examination
- ❑ Consultation Reports
- ❑ Mental Health Care or Services
- ❑ Diagnosis, Treatment and/or Referral for Alcohol and/or Drug Abuse
- ❑ Photographs, Videotapes, Digital or Other Images
- ❑ Progress Notes
- ❑ Laboratory Tests
- ❑ X-ray Reports

Please specify date(s) of treatment:

_____

❑ Other (please specify):

_____

_____

Note: If Psychotherapy Notes are being authorized for disclosure, then a separate Authorization for Psychotherapy Notes needs to be signed.

Person(s) Authorized to Make the Use or Disclosure:

The following persons or class of persons are authorized to make the specified use or disclosure of this information: Hamilton Medical Center, Inc. and its covered entity Affiliates, as well as their employees, agents, medical staff and contractors.

Recipient(s) of Use or Disclosure:

This information may be used by or disclosed to the following persons or class of persons:

_____

_____

Purpose(s) of the Use or Disclosure:

A description of each purpose of the use or disclosure is as follows:

_____

_____

OR

- ❑ I am requesting the use or disclosure of the Patient's information pursuant to this Authorization, and the information will be used and disclosed at my request.

Expiration:

This Authorization will expire on the following date or event: _____ (or within one (1) year if no other date is specified); or

If this Authorization is for research purposes, it will expire

- ❑ At the end of the research study, or
- ❑ It will have no expiration date because the project provides for the creation and maintenance of a research database or research repository.

How to Revoke This Authorization

I understand I may revoke this Authorization by submitting a written revocation, on a form provided by Hamilton, to Hamilton Medical Center, Attention: Medical Records Department, P.O. Box 1168, Dalton, Georgia 30722-1168 or by facsimile at (706) 272-6049. I may obtain the revocation form by calling Hamilton Medical Center's Medical Records Department at (706) 272-6040. However, a submitted revocation shall not be effective with respect to any use or disclosure made by Hamilton in reliance on this Authorization prior to the date of Hamilton's receipt of my revocation.

Authorization as a Condition

I understand Hamilton cannot require me to sign this Authorization as part of treatment, payment, health plan enrollment or eligibility for benefits, except as otherwise permitted by HIPAA. If the provision of healthcare by Hamilton is solely for the purpose of creating PHI for disclosure to a third party (e.g., an employee physical exam) or is for research-related treatment, I understand that Hamilton will not provide the service unless I sign this Authorization.

Further Use

I understand that the Patient's PHI will not be further used or disclosed in exchange for remuneration (payment) to Hamilton, without a separate authorization.

Potential Redisclosure

I understand that the information used or disclosed by Hamilton pursuant to this Authorization may be subject to redisclosure by the recipient in which case it might no longer be protected under HIPAA. However, I understand that in some cases, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize Hamilton to copy this Authorization and to send the recipient the redisclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether or not the Patient's records contain information protected by those laws.

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[Hamilton to Complete the Following if Use or Disclosure involves Marketing or a Sale of PHI]

- ❑ The requested use or disclosure involves marketing or a sale of PHI under HIPAA.

  Such use or disclosure ❑ will ❑ will not involve remuneration (payment) to Hamilton, whether directly or indirectly.

[Applicable for Research Authorization]

I understand that if this Authorization pertains to a research project, my right to obtain access to the Patient's PHI contained in a research database can be suspended for as long as the research project is in progress. I understand and agree to this temporary denial of access, and I understand that such right of access to PHI contained in the research database will be reinstated upon completion of the research. If the Patient is participating in a research study that requires the signing of this Authorization, I understand I can request additional information about (1) other research activities, if any, that do not require a signed authorization; and (2) the ability to opt in to such other research activities.

Unless my disagreement is initialed at the end of this sentence, I understand and agree that the Patient's PHI can be used or disclosed for future research consistent with HIPAA and that such PHI may include information collected after the end of the original study. _____ (Initials)

[Applicable if Authorization is Requested by Hamilton]

I understand that if this Authorization is being requested by Hamilton, I must be provided with a copy of the signed Authorization.

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1 have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby voluntarily release Hamilton Medical Center, Inc., its Affiliates, and their officers, trustees, employees, agents, medical staff and contractors from any liability, damages and expenses arising in connection with the use or disclosure of the Patient's protected health information pursuant to this Authorization. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

_____ _____

Print Patient Name Date

_____

Patient Signature

_____

Print Patient's Authorized Representative Name

_____

Signature of Patient's Authorized Representative

Basis of authority to sign for patient: _____

[Note: Copy of the signed Authorization to be provided to Patient]

I will pick up records upon notification of their completion_____

Phone number for notification_____

Mail records (make sure address is correct) _____

Ciox Health is a contracted release of information vendor here at **Hamilton Medical Center in** Health Information Management Services. Below are the standard fees for producing a copy of your medical records by Ciox Health.

Fees for the copy of your medical record are as follows:
$6.50 for records delivered electronically
or
for paper delivery/pick up
$0.90 labor fee
$0.05 per page fee for toner & supplies
Applicable postage (if mailed) and taxes

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee either in advance, when services are rendered, or when I receive an invoice from CIOX Health.

NAME:_____ PHONE #: (____)_____

ADDRESS:_____
Street City State Zip

SIGNATURE:_____ DATE:_____

QUESTIONS?? PLEASE CALL 706-272-6345.