ADDRESSOGRAPH

NH2493

NORTHSIDE HOSPITAL, INC.

English - Spanish - Korean

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Name of Patient: _____

Patient's Date of Birth: _____

Phone #: _____

Address: _____

_____

I hereby authorize Northside to disclose my health information from the following facility/facilities as directed below:

☐ Northside Hospital-Atlanta ☐ Northside Hospital-Forsyth ☐ Northside Hospital-Cherokee ☐ Northside Hospital Behavioral Health Services
☐ Northside Hospital-Gwinnett ☐ Northside Hospital-Duluth ☐ All hospital campuses ☐ Other: _____

I understand that in some instances my medical record may also include my health information from other healthcare facilities owned and/or operated by Northside Hospital, Inc.

The Northside Hospital Office Practice identified above is hereby authorized to (**Please mark appropriate box**):
☐ **Release to OR** ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) (**Please identify by name or general description and provide address, if known**): _____

_____

The following protected health information regarding the patient (Please mark appropriate box(es)): ☐ Complete Medical Record
☐ Abstract of Medical Record (physician dictated reports & diagnostic reports) ☐ Labs only ☐ Radiology only ☐ EKG only
☐ Billing Records ☐ Other (Please specify clearly): _____

For the following dates of service: Start Date: _____ End Date: _____

In the following format: ☐ Paper ☐ Electronic **Need records certified:** ☐ Yes ☐ No

Unless you state otherwise, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse, including drugs and alcohol**, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a separate consent form is generally required.

Unless you state otherwise by marking one or both boxes below, this authorization includes the release and disclosure of records and information which may include (i) **"HIV/AIDS confidential information"** and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider and you **affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/AIDS Confidential Information** is defined by Georgia law to include the fact that a patient has had an HIV test or has been counseled about HIV, even if the test is negative. **Note:** Unless otherwise permitted by law, the release of **"HIV/AIDS confidential information"** and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I **object** to the release of "HIV/AIDS confidential information".
☐ I **object** to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is: _____

I understand that my/ the patient's treatment at Northside Hospital will not be affected if I refuse to sign this authorization. I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage **Note:** This authorization can be revoked by submitting a written request to the Health Information Services Department of Northside Hospital at 1000 Johnson Ferry Road, Atlanta, Georgia, 30342.

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:
(a) _____ **(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit,)**; (b) the date I revoke this authorization in writing; or (c) three (3) years from the date I sign this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries, or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____
Signature of Patient or Legally Authorized Representative Date/Time

Relationship to patient: _____

Reason patient unable to sign: _____

_____
Interpreter (if applicable) Date/Time
Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

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Reason patient unable to sign: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Original - Medical Records
Yellow Copy - Patient