Release of Information Policies

1. To properly assist in handling your request for medical information, please completely fill out both pages of the authorization form and sign the patient fee sheet.
2. Your request for information will be submitted for processing and ready within 7 to 10 business days. If needed, the records may be picked up and you will be notified once the records are ready. This policy is nullified for medical emergencies only.
3. All authorizations must be dated and signed by the patient, unless he/she is a minor, deceased, physically and/or mentally impaired, or has appointed a Durable Healthcare Power of Attorney or has a court appointed guardian. Due to State and Federal laws, no exceptions will be made.
4. Written authorization is required.

<u>Release Information Fees for Patients</u>

Copy Costs:

1-20 pages $.97/page

21-100 pages $.83/page

100 or more pages $ .66/page

There is a $10 minimum

Your questions regarding Release of Information are welcomed. Please contact the facility directly for any questions. 770-997-5714

By signing below, I acknowledge that I have read the above procedures regarding the release of medical records.

_____ _____

Patient/Representative Signature Date of Signature

WOMEN'S Medical Center

*Medical Record Number:*_____
(For internal use)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

HEALTH INFORMATION MANAGEMENT DEPARTMENT

Patient Name: _____ Last 4 digits of SSN: _____

Previous Name, if applicable: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____Home Phone: _____Work Phone: _____

Email address: _____

1. **Women's Medical Center:**
   I authorize Women's Medical Center representatives to disclose the health information as directed below:

2. **Receiving Party and Method of Delivery:**
   - o Mail
   - o Pick Up

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Fax Number (continuing patient care support only): _____

3. **Description of Health Information To Be Disclosed:**

- o Complete medical record (Please specify dates of service) _____
  OR
- o Partial Medical Record (Please specify records below)
- o Electronic Continuity of Care/Electronic Abstract(please specify dates of service) _____
- o You must check this box if you are also requesting Billing Records

Information	**Dates**
o History & physical	_____
o Consultations	_____
o Discharge summary	_____
o Lab results	_____
o X-rays	_____
o CD/Films	_____
o Itemized Bill	_____
o Office Notes/Progress Notes	_____
o Operative reports	_____
o Pathology Slides	_____
o EKG Reports	_____
o Photo/Videos	_____
o ED Record	_____

Over

WOMEN'S
Medical Center

*Medical Record Number:*_____
(For internal use)

- o Rhythm Strips _____
- o Pathology Slides _____
- o Other (please specify dates of service:

_____

4. Purpose of Disclosure

- o At my request
- o Other: _____

5. Expiration of Authorization

Unless I request in writing otherwise, I understand that this is authorization will expire on _____ (Insert expiration date or event). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

6. Right to Revoke Authorization

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the Women's Medical Center facility. An address for the Medical records department is contained in the Women's Medical Center website or listed here (190 Handley Rd., Ste. A, Tyrone, Ga 30290). I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. Re-Disclosure

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

8. Fees

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

9. Release and Waiver

If the health information that I have requested Women's Medical Center to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for this purpose(s) of releasing it to the party or parties authorized above. I also release Women's Medical Center, their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me.

_____ _____ _____

Signature of Patient (or Patient's Representative) Date Time

_____ _____

Printed Name Description of Authority to Act for Patient

Over