EMORY HEALTHCARE

Release of Information Policies

1. To assist in properly handling your request for medical information, please **fill out the entire authorization form.**
2. **Provided the medical record is complete and contains all the reports, documentation and appropriate signatures, requests for information will be processed within 24 to 48 working hours after receipt and delivered by mail within 7 to 10 business days.** If needed, records may be picked up Monday through Friday between 8am to 5pm. You will be notified within 48 working hours that the records are ready. Records for medical emergencies are generally faxed to the hospital or physician.
3. All authorizations must be dated **after** discharge and **signed by the patient,** unless he/she is a minor, deceased, physically and/or mentally impaired, or has appointed Power of Attorney or Guardian. A copy of the Power of Attorney or Guardianship documentation must accompany the request. Due to State and Federal regulations, **no exceptions will be made.**
4. **Written authorization is required.**

State of Georgia Fee Schedule (patient)
Chapter 33 of Title 31 of the official code of Georgia annotated, Section 2-a

Payment is required prior to the records being furnished.
The fee for copies of paper health information is:
$0.93 per page (pages 1-20)
$0.80 per page (pages 21-100)
$0.63 per page (pages 101 +)

Certification Fee $9.32
Radiology - CD - $25.00 each disc
- film - $12.00 each sheet

If your written request for medical information has not already been filled out and submitted, please complete the authorization release form.

The release of Information Section of Emory Healthcare is managed by **SDS Health.** Your questions and comments are welcome.

1-800-367-1500
Release of Information at Emory University Hospital
1364 Clifton Rd. NE
C-228
Atlanta, GA 30322
Phone: 404-712-4556
Fax: 404-712-4164

EMORY HOSPITALS

Authorization For The Release of Protected Health Information Medical Records Department

Please fax your request to: 404-712-4164
or
Mail to: EUH-Medical Records/ROI
1364 Clifton Rd. NE, RM C-228
Atlanta, GA 30322

Date: ____/____/____ Time: ____________ Medical Record Number: ________________
(for internal purposes)

Patient Name: ______________________________ Social Security Number: ________________

Previous Name, if applicable: ______________________________

Address: ____________________ City: ____________________ State: ______ Zip Code ________

Date of Birth: ______________ Home Phone: ______________ Work Phone: ______________

1. **Emory Healthcare Facility/Facilities:**

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

(Check one or more):

- ☐ The Emory Clinic
- ☐ Emory University Hospital
- ☐ Center for Rehab. Medicine
- ☐ Emory Children's Center
- ☐ Emory Medical Affiliates
- ☐ Dialysis Access Center of Atlanta
- ☐ Emory Crawford Long Hospital
- ☐ Wesley Woods Geriatric Hospital
- ☐ Wesley Woods Outpatient Clinic
- ☐ Wesley Woods Long Term Care Hospital
- ☐ Budd Terrace
- ☐ Other: ____________________

2. **Receiving Party**

Please send my health information to:

Name: ______________________________

Address: ______________________________

City: ______________ State: __________ Zip Code: __________

Fax Number: ______________________________

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

☐ Complete medical record *(Please specify dates of service)* ____________________
OR
☐ Partial medical record *(Please specify records below)*

☐ *You must check this box if you are also requesting Billing Records*

Information	Dates	Information	Dates
☐ History & physical	______	☐ Office notes	______
☐ Consultations	______	☐ Operative reports	______
☐ Discharge summary	______	☐ Pathology reports	______
☐ Lab results	______	☐ EKG reports	______
☐ X-rays	______		

☐ Other *(Please specify dates of service)*: ______________________________

4. **Purpose of Disclosure**

- ☐ At my request
- ☐ Other: ______________________________

Medical Record Number: ________________ *(for internal purposes)*

5. **Expiration of Authorization**

Unless I request in writing otherwise, I understand that this 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 Emory Healthcare facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Emory Healthcare, Inc. Notice of Privacy Practices. 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. **Refusal to Authorize Use and/or Disclosure**

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Emory Healthcare may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

10. **Release and Waiver**

If the health information that I have requested Emory Healthcare 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), Veneral Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Emory Healthcare, each of the Emory Healthcare facilities checked above, and 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 above.

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

____
Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR PATIENT'S REPRESENTATIVE AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD