Ridgeview Institute - Smyrna
3995 South Cobb Drive
Smyrna, Georgia 30080
Phone: 770-434-4567
Fax: 770-431-7043

Ridgeview Institute - Monroe
709 Breedlove Drive
Monroe, Georgia 30655
Phone: 678-635-3542
Fax: 678-635-3548

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ______________________ **DOB:** ____________
SSN: ______________________ **Phone #:** ______________________
Dates of Treatment Requested: ______________________
MRN: ______________________ **Account #:** ______________________

I hereby request and authorize Ridgeview Institute to:
☐ **Release my PHI to entity below** ☐ **Request my PHI from entity below**
Name/Entity: ______________________ **Attn:** ______________________
Address: ______________________
City: ______________________ **State:** ____________ **Zip:** ____________
Phone: ______________________ **Fax:** ______________________

Delivery Method: ☐ Pick-Up ☐ Mail ☐ Fax
Purpose of Request: ☐ Continuation of care ☐ Other: ______________________

PHI to be Released From: ☐ Ridgeview Institute – Smyrna ☐ Ridgeview Institute – Monroe

Requested PHI:
☐ Abstract (no fee—consists of Psych Evaluation, History & Physical, Discharge Summary, Psychological Evaluation)
☐ Facesheet
☐ History & Physical
☐ Psychiatric Evaluation (Database)
☐ Entire record (fees associated)
☐ Discharge Summary
☐ Treatment Plans
☐ Consultations
☐ Initial Clinical Assessment
☐ Other: ______________________

I understand that:
1. Authorization is voluntary and treatment will not be contingent upon my signing this form.
2. Any disclosure of protected 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 information herein requested.
3. 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 judgement of the medical staff, disclosure of the protected health 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.
4. After giving due consideration of 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.
5. I have the right to revoke this authorization at any time and that revocation requests must be submitted in writing. I understand that 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.
6. Unless withdrawn before fulfillment, this authorization will automatically expire upon completion of this request.

Patient/Patient Representative Signature: ______________________

Printed Name: ______________________

Relationship to Patient: ______________________ **Date:** ____________

FOR INTERNAL USE ONLY
Received on: __________ ☐ Form valid/complete ☐ ID verified/POA paperwork received ☐ Date released: ____________ ☐ Completed in MedHost by: ________
Notes: ______________________