Medical Record Number: _____
(for internal purposes)

EMORY HEALTHCARE

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. **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 Specialty Associates
- ☐ Dialysis Access Center of Atlanta
- ☐ Saint Joseph's Hospital of Atlanta
- ☐ The Medical Group of Saint Joseph's, LLC
- ☐ Emory Johns Creek Hospital
- ☐ Emory University Hospital Midtown
- ☐ Emory University Orthopaedics and Spine Hospital
- ☐ Wesley Woods Health Center
- ☐ Wesley Woods Geriatric Hospital
- ☐ Wesley Woods Outpatient Clinic
- ☐ Budd Terrace
- ☐ Other: _____

2. **RECEIVING PARTY, FORMAT, AND METHOD OF DELIVERY:**

FORMAT:
- ☒ On Paper
- ☐ On CD
- ☐ Flash Drive

METHOD OF DELIVERY:
- ☐ Mail (Complete info below)
- ☐ Pick up (List by whom below)
- ☐ EHC Electronic Release of Information Request Website (In order to receive records via the electronic website, you must create an account through the website, then submit your request via the website. Please see attached instructions)
- ☐ Via Email (Please provide email address above) Please note, due to file size limits for our organization, records sent via email are restricted to a small number of pages.

Name: RECORDS DEPOSITION SERVICE, INC.
Address: PO BOX 5054
City: SOUTHFIELD State: MI Zip Code: 48083-5054
Telephone Number: 248-357-3330
Fax Number (continuing patient care support only): 248-357-3337

3. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**

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

Information	Dates	Information	Dates
☐ History & physical	_____	☐ Office notes/Progress notes	_____
☐ Consultations	_____	☐ Operative reports	_____
☐ Discharge summary	_____	☐ Pathology reports	_____
☐ Lab results	_____	☒ Pathology slides	_____
☐ X-rays	_____	☐ EKG reports	_____
☐ CD/Films	_____	☐ Photo/Videos	_____
☐ Cath Record	_____	☐ ED Record	_____
☐ Itemized Bill	_____	☐ Rhythm Strips	_____
☐ Other *(Please specify dates of service):*		☐ Pathology Slides	_____

4. **PURPOSE OF DISCLOSURE**

- ☐ At my request Need Records Certified ☐ Yes ☐ No
- ☑ Other: PRE TRIAL DISCOVERY

Medical Record Number: _____
(for internal purposes)

5. **Important Notice**

If you are requesting your medical information via e-mail, please be sure that you have provided us with an accurate e-mail address. E-mail and attachments will be sent to you in an encrypted format with instructions on how you retrieve the information. Once you receive the e-mail we encourage you to maintain the information in a secure manner and use caution when forwarding or allowing access to your e-mail. Also, the CD or flash drive you receive containing your medical health information may not be encrypted or password protected. Once you have received your medical information from EHC we encourage you to take precautions to protect the data on the device through encryption or storing the device in a secure manner. By choosing to receive **your health information** on a CD or flash drive, you are acknowledging and accepting these risks.

6. **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.

7. **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.

8. **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.

9. **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.

10. **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 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).

11. **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), Venereal 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	Time
Printed Name	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

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