Medical Record Number: _____
(for internal purposes)

EMORY MEDICAL LABORATORY
AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security Number: _____

Previous Name, if applicable: _____

Address: _____ City: _____ State: _____

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):

- ☐ Emory Clinic
- ☐ Emory University Hospital
- ☐ Emory Rehabilitation Hospital
- ☐ Emory Medical Affiliates
- ☐ Dialysis Access Center of Atlanta
- ☐ Emory University Hospital Midtown
- ☐ Emory Wesley Woods Hospital
- ☐ Emory Children's Center
- ☐ 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:

Information	Dates	Information	Dates
☐ Lab Results	_____	☐ Pathology Slides	_____
☐ Pathology Results	_____	☐ Pathology Blocks	_____

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

4. PURPOSE OF DISCLOSURE

- ☐ At my request
- ☐ Other: _____

Positive ID Methods of Authentication

Acceptable methods for positive identification: Select one to fax with completed Authorization form.

- *Copy of photo identification (passport, Driver's license)*
- *Last four digits of Patient's Social Security number*
- *Patient's last name, patient's first name, patient 's date of birth*
- *Patient 's address and phone*

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.

Medical Record Number: _____
(for internal purposes)

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),

Mail To: Emory Medical Laboratory 1364 Clifton Road Atlanta, GA 30322	or	Fax to: 404-712-0828 or For Pathology Requests 404-712-2052

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

_____

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