DONALSONVILLE HOSPITAL INC. & BEHAVIORAL HEALTH **PHONE: (229) 524-5217**
102 HOSPITAL CIRCLE **FAX: (229) 524-8957**
DONALSONVILLE, GA 39845 **BHU PHONE: (229) 524-2254 FAX: (229) 524-2256**

Patient Authorization for Release of Medical Information

Patient's Name:	Date of Birth:	Telephone #:
Patient's Address:		
Patient Account #:		
Email Address:		

If you wish to receive your records via e-mail, flash or other drive or on CD, please read and initial below.

_____ (Initial) I understand that there is a risk to me when my PHI is transmitted via an email system, to a private or work email account, or via unencrypted CD or drive because the PHI could be accessed by a third-party during storage or transmission or in transit. By initialing and requesting email delivery or a CD, I accept this risk.

I hereby authorize **DONALSONVILLE HOSPITAL, INC. & BEHAVIORAL HEALTH** ("Health System"), together with its employees, agents and contractors, to use or disclose my personal information and/or protected health information covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 and other applicable federal and state law -- as specified in this Authorization. I understand that this request could include records disclosed to the Health System by providers outside Health System.

I understand that this authorization allows the release of the records that could include personal, sensitive, protected health or financial information (eg, social security number, banking information, policy numbers, credit information) and may include highly sensitive information (such as genetic information; sexual orientation/habits; alcohol and drug use/abuse tests/treatment information; reproductive health information such as pregnancy, abortion, birth control, etc; mental health or developmental disability, tests, diagnosis treatment or related communications including depression/anxiety drugs/information; or information relating to testing or treatment of venereal / contagious diseases (e.g., COVID, Hepatitis, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), etc

I expressly authorize the release of the following including all contents: (check all that are authorized for release):

□ Copy of full medical record with images **□ Copy of full medical record without images** **□ Emergency Room Record only**	**OR copy of these only:** **□ Discharge Summary** **□ Medication Records** **□ History / Physical Examination**	**OR copy of these only:** **□ Radiology** **□ Pathology Report** **□ Billing Records (invoices)** **□ Other:** _____ _____	**OR copy of these only:** **□ Progress Notes** **□ Operative Notes / Reports** **□ Lab Reports**

Date range requested: Records checked above from _____ through _____

****I authorize release of any information in my medical records regarding diagnosis/treatment of alcohol/drug abuse, psychiatric or mental illness, communicable diseases, immunodeficiency syndrome (AIDS) or tests for human immunodeficiency virus (HIV). _____ Initial ****

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*****I authorize the release of information about my or my partner's / surrogate's reproductive health (including but not limited to the following: birth control, pregnancy tests, sterilization, fertility tests and results, fertility treatments, abortions, contagious / sexually transmitted diseases, termination of pregnancy, erectile disfunction and treatment, hormones, etc.)** _____ **Initial *****

******I authorize the release of any psychotherapy notes in my medical record.** _____ **Initial ******

To be used by or released to: _____

For the following purpose: personal or Other _____

I am requesting the use or disclosure of my information pursuant to this authorization, and the information will be used and disclosed at my request.

I understand this authorization may be revoked by submitting a written revocation on a form provided by the Health System to me, provided that such revocation shall be effective with respect of any use or disclosure made by the Health System in reliance or this Authorization prior to the date of the Health System's receipt of my revocation.

This Authorization will expire one year from the date it was signed.

I understand that the Health System cannot require me to sign this Authorization in order to receive treatment unless the provision of healthcare by the Health System is solely for the purpose of creating protected health information for disclosure to a third party (e.g., and employee physical exam) or for research-related treatment, in which situations the Health System will not provide the service unless I sign this Authorization.

I understand that the information used or disclosed by the Health System pursuant to this authorization may be subject to re-disclosure by the recipient in which case it might no longer be protected under the HIPAA Privacy Rule or federal or state law. I understand the information released may be used against me – including for prosecution or to deny a job or claim.

I authorize the Health System to copy this Authorization and to send the recipient the re-disclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether or not my records contain information protected by those laws.

I have read and understood this Authorization and my questions have been answered. I certify that I am the Patient listed above or a person legally authorized to permit release of records on a patient's behalf. I hereby release the Hospital and its officers, trustees, employees, agents, and contractors from any liability arising in connection with the use or disclosure of my protected health information pursuant to this Authorization.

I understand that if this Authorization is being requested by the Hospital, the Hospital must provide me with a copy of the Signed Authorization upon request.

I understand if I do not agree to all the disclosures allowed by this Authorization, then I can ask the Health System Privacy Officer to revise it to cover the areas I wish to be disclosed.

_____	_____	_____	_____
Print Patient Name	Patient Signature*	Date	Time
_____	_____	_____	_____
Print Witness Name	Witness Signature	Date	Time

*If patient is unable to consent, I hereby consent on behalf of the patient name on this authorization:

_____	_____	_____	_____
Print Authorized Representative Name/Relationship	Signature of Patient's Authorized Representative	Date	Time

This authorization shall become a permanent part of the patient record.