West Georgia Cardiology

♥129 Bankhead Highway ♥ Carrollton, GA 30117♥♥Main: (770) ♥838♥8440 Fax: (770) ♥838♥8443♥

Authorization For Use/Disclosure of Protected Health Information

I hereby request and authorize (*print name of hospital/physician*): **West Georgia Cardiology** to:

Provide **copies** of my records to:
Name (*receiving person/party*): _____
Address: _____
Fax #: _____ Phone# (required to verify Fax #): _____

This authorization applies to records or WGC access from the following date or dates of service: _____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but **may include** other detailed mental health information, HIV/AIDs information and/or information regarding alcohol or substance abuse.

◊ Entire Medical Record
◊ **Abstract of Records****
◊ Cardiac Cath Report
◊ Cardiac Rehab
◊ Consultation Report
◊ Coumadin Reports
◊ Discharge Summary Reports
◊ Demographics
◊ Doctor's Orders
◊ Electro Cardiogram (ECG/EKG) Report
◊ Emergency Room Report
◊ History & Physical Report
◊ Laboratory Test Results
◊ Medication Records
◊ Operative Report
◊ Pacemaker/ICD Implant Report
◊ Pulmonary Function Test
◊ Radiology Reports
◊ Stent/Bypass Report
◊ Stress Tests
◊ Ultrasound _____
◊ Diagnostic Reports
◊ Other-Specify _____
◊ Notes-Specify _____

****An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Report, and diagnostic test results.**

Purpose of Use or Disclosure: ◊ At the request of the individual (patient)
◊ Other _____

The following information is needed to assist the provider in location the patient's records:

Patient's Full Name: _____ Patient's SSN: XXX-XX-_____
Maiden/Other Name: _____ Patient's Date of Birth: _____
Patient's Phone # (Home): _____ (Work): _____ (Cell): _____
Current Address: _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from the Medical Records Department. The completed revocation must be presented to the Medical Records Department. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. WGC Providers shall not condition treatment on the receipt of this Authorization, except when such conditions is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams.)

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here** _____

_____ _____ _____
Patient's or Legal Representative's Signature **Please Print Name** **Today's Date**

As Legal Representative, my relationship to the patient is _____. Any document providing such authority must be attached. The patient is unable to sign because _____.

Note: There may be fees for provision of any or all requested information. Under most circumstances, the law permits up to 30 days for records requests to be processed, however records for treatment purposed can be immediately faxed to the patient's healthcare provider when requested.