Ridgeview Institute Smyrna
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Smyrna, Georgia 30080
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____

Account/Patient #: _____ Phone #: _____

Approximate Dates of Treatment Requested: _____

PHI to be Released From: ☐ Ridgeview Institute Smyrna ☐ Other: _____

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: _____

E-Mail: _____

Delivery Method: ☐ Pick-Up ☐ Mail ☐ Fax ☐ E-Mail*

**Ridgeview Institute is not responsible for unauthorized access to the PHI contained in this format or any risks (e.g. viruses) potentially introduced to your computer or device when receiving PHI in electronic format or email.*

Purpose of Request: ☐ Continuation of care ☐ Other: _____

Requested PHI:

☐ Abstract copy (no fee; consists of Psych Evaluation, History & Physical, and Discharge Summary)
☐ Entire record (fees associated)
☐ Other: _____
☐ Psychiatric Evaluation
☐ Discharge Summary
☐ Master Treatment Plan
☐ Lab results
☐ Psychosocial Assessment
☐ Itemized bill

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.
4. _____ ***(initial)*** The information/records to be released may include alcohol and/or drug abuse treatment information, AIDS/HIV, sexually transmitted disease infections, or psychiatric/psychological/mental health privileged or confidential information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.
5. 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.
6. 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. Unless withdrawn before fulfillment this authorization will automatically expire upon completion of this request.
7. Unless otherwise revoked, this authorization is only valid for a period of six (6) months from the date of my signature below, unless I specify a date/event here: _____

Patient/Patient Representative Signature: _____

Printed Name: _____

***Relationship to Patient:** _____ **Date:** _____

*Please note: *A copy of your ID and applicable supporting documentation must be submitted for verification purposes.*