Archbold

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient listed on this form specifically authorizes Archbold to use and disclose Patient's protected health information (including highly sensitive financial, billing and medical information) that is maintained by Archbold in the ways noted in this Authorization. Patient understands protected health information could include records disclosed to Archbold by outside healthcare providers who previously provided treatment to Patient. Patient understands that information may include highly sensitive information, such as social security numbers, credit card numbers, insurance numbers, or information about genetics, mental health or developmental disability, viruses, diseases, disabilities, dysfunctions, alcohol & drug abuse, abortion/pregnancy/birth control, or testing/treatment for AIDS (Acquired Immunodeficiency Syndrome) / HIV (Human Immunodeficiency Virus) or communicable, venereal, or sexually transmitted diseases, disabilities, etc.**

****I understand "Archbold" as used in this Authorization means *(1) John D. Archbold Memorial Hospital, Inc.,* which includes Archbold Memorial, Archbold Grady, Archbold Brooks, and Archbold Mitchell, and all of their on-campus and off-campus provider-based departments, facilities, rural health clinics, pharmacies, durable medical equipment provider, hospices; Archbold Northside, Archbold Living Thomasville, Archbold Living Camilla, Archbold Living Pelham, and Archbold Living Cairo; and **(2) Archbold Medical Group, Inc.**, which owns and operates multiple physician medical practices. Website www.archbold.org ("Locations" tab) explains more about Archbold locations. I understand the Archbold representative can also help me.*

READ AND COMPLETE ALL SECTIONS ON PAGES 1-3, DATE, AND SIGN THIS FORM IF YOU AGREE TO THIS USE AND DISCLOSURE OF PATIENT'S HEALTH INFORMATION.

I. This Form Authorizes the Use & Disclosure of the following Patient's Protected Health Information:	
PATIENT NAME:	
DATE OF BIRTH	SOCIAL SECURITY NUMBER
PATIENT ENCOUNTER	MEDICAL RECORD NUMBER
STREET ADDRESS	
CITY, STATE, ZIP CODE	
PHONE	EMAIL

II. Patient's Protected Health Information is to be Disclosed or Provided to:	
NAME	
STREET ADDRESS	
CITY, STATE, ZIP CODE	
PHONE	EMAIL

III. Purpose of Use or Disclosure of Patient's Protected Health Information:

☐ Continuing Care ☐ Legal ☐ Disability ☐ Other: _____

IV. **Patient's Protected Health Information to be Disclosed:*** *(Check applicable box.)*

☐	Abstract of Patient Medical Record* (which includes History and Physical, Discharge Summary, Consultation Reports, Emergency Department Record, Laboratory Reports, Radiology Reports, Operative Reports and Pathology Reports) from_____(date) to_____(date)
☐	All Patient medical records* for the period of time from_____(date) to _____ (date) for the following Archbold entities/facilities: _____
☐	Only the Patient medical records* for the period of time from _____ (date) to _____ (date) from the following Archbold facilities: _____
☐	Other Patient records* - *e.g., Psychotherapy Notes (requires a separate authorization form), Billing records, etc.* _____

*** Patient agrees records disclosed will include Patient's Sensitive Information, such as social security numbers, or other financial information or information about genetics, mental health/developmental disability, alcohol & drug abuse, abortion/pregnancy/birth control, testing/treatment for AIDS/HIV, communicable, venereal, or sexually transmitted diseases, etc.**

V. Format. Provide the Patient Health Information (including Sensitive Information) by:

☐ Sending a Fax* with the PHI to Fax Number: _____

☐ Emailing* the PHI to address: _____

☐ Saving the Patient Information on an Unencrypted CD**

☐ Making a Paper Copy

Fax/Email will be encrypted in route but may not be secure in server upon arrival, opening, storage, etc.
****CD will not be secured by password / encryption and could be downloaded by anyone with access to the CD.***

VI. Fees. Patient understands there may be fees charged for this request for information - which will be charged in compliance with state & federal copying laws. An estimate of those fees may be requested.

VII. Right to Revoke. Patient understands that he/she may revoke this Authorization in writing by completing a revocation form provided by Archbold and submitting the completed form to the

Director of Health Information Management, 900 Cairo Road, Thomasville, Georgia, 31792, except to the extent that information has already been used or disclosed in reliance on this Authorization prior to revocation.

VIII. Expiration Date or Event. If this Authorization has not been revoked, it will terminate 2 years from the date it is signed, unless a different expiration date or expiration event is stated below:

_____

(If desired, specify different expiration date or expiration event.)

IX. Voluntary. Archbold cannot condition Patient's treatment or eligibility for care on Patient signing this Authorization, except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party (*e.g.,* employee physical exam).

X. Re-disclosure. Patient understands that information disclosed by this Authorization will likely be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy rule, federal or state privacy or consumer protection laws.

I certify that I am the Patient listed on page 1 (or authorized legal representative for Patient), and I consent to this use or disclosure of Patient protected health information and sensitive health, financial and personal information. I hereby release Archbold from any liability for this use, disclosure or any re-disclosure of Patient's protected health information.

SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED LEGAL REPRESENTATIVE	**DATE/TIME**
IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME AND BASIS OF AUTHORITY TO SIGN FOR PATIENT:	
WITNESS SIGNATURE	**DATE/TIME**

Archbold

Health Information Management Department
900 Cairo Road
Administrative Services Building
Thomasville, GA 31792

REVOCATION OF AUTHORIZATION

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

Patient Encounter (if known): _____ **Medical Record # (if known):** _____

Address: _____

Phone #: _____ **Email Address:** _____

- Patient, identified above, revokes the Authorization For Use or Disclosure of Protected Health Information Patient previously granted to Archbold* on _____.
  Date of Authorization
- This Revocation shall not be effective with respect to any use, disclosure or re-disclosure of Patient's protected health information by Archbold* prior to Archbold's receipt of this Revocation or any future use or disclosure by any previously authorized recipient of Patient's Protected Health Information. Patient understands that Archbold has no control over re-disclosure of Patient's protected health information previously disclosed under Authorization.
- Archbold* shall still be allowed to use and disclose Patient Protected Health Information in accordance with its Notice of Privacy Practices for treatment, payment and health care operations and other uses/disclosures allowed by state and federal law.
  ***"Archbold" means (1) John D. Archbold Memorial Hospital, Inc.,** which includes Archbold Memorial, Archbold Grady, Archbold Brooks, and Archbold Mitchell, and all of their on-campus and off-campus provider-based departments, facilities, rural health clinics, pharmacies, durable medical equipment provider, hospices; Archbold Northside, Archbold Living Thomasville, Archbold Living Camilla, Archbold Living Pelham, and Archbold Living Cairo; and **(2) Archbold Medical Group, Inc.**, which owns and operates multiple physician medical practices. Website www.archbold.org ("Locations" tab) explains more about Archbold locations. I understand the Archbold representative can also help me.*

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IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME AND BASIS OF AUTHORITY TO SIGN FOR PATIENT:	
WITNESS SIGNATURE	**DATE/TIME**