6450D

Medical Record #: _____

Date Record Needed: _____

I _____ authorize and request Memorial Health University Medical Center to Use or Disclose My Personal Health Information of the patient described below.

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

HOME PHONE: _____ WORK PHONE: _____

1. **Description of Health Information that may be used and/or disclosed:**

☐ EMERGENCY ROOM CHARTS ☐ COMPLETE CHART

☐ ABSTRACT (Discharge Summary, History and Physical, Operative Report)

☒ OTHER Please see enclosed Subpoena or Letter Request for information to be disclosed.

DATES COVERED IN REQUESTED RECORDS: From _____ to _____

I am aware that some of the Health Care information or other information contained in the requested medical records may be confidential or privileged and I hereby specifically waive any privilege or confidentiality existing under Federal or State law regarding such information including, but not limited to, protection afforded to:

☐ *Communications made to psychiatrist (O.C.G.A. §424-9.21)*

☐ Communications made to a licensed applied psychologist (O.C.G.A. §43-39-16)

☐ Medical information concerning drug dependency (O.C.G.A. §26-5-17)

☐ Medical information concerning alcohol and drug dependency (O.C.G.A. §37-7-166)

☐ Medical information regarding mental illness (O.C.G.A. §37-4-125)

☐ Medical information regarding mental retardation (O.C.G.A. §37-4-125)

☐ Medical information concerning alcohol and drug abuse (42 C.F.R. PART 2)

☐ A.I.D.S. confidential information (O.C.G.A. §31-22-9.1 AND §24-9-47)

2. **Name(s) of organization(s) or person(s) who may use and/or disclose the information:**

Memorial Health University Medical Center
(NAME)

(ADDRESS) (CITY, STATE, ZIP CODE)

3. ***Name(s) of organization(s) or person(s) who may receive and use the information:***

RECORDS DEPOSITION SERVICE, INC. **P: 312-553-8900**
(NAME)

120 W. MADISON STREET, STE. 300, CHICAGO, IL 60602 **F: 312-553-8901**
(ADDRESS) (CITY, STATE, ZIP CODE)

Memorial HEALTH University Medical Center

AUTHORIZATION AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

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Patient ID Area

4. **The purpose(s) for which the information will be used or disclosed (the purpose may be stated as "at the request of the individual" if the individual initiates this Authorization and does not provide a statement of purpose):** FOR DISCOVERY BEFORE TRIAL

5. **This Authorization will expire on _____. (Insert an applicable date or an event that relates to the individual or the purpose of the use or disclosure).**

I understand that, if the recipient of the information is not a health care provider or health plan covered by the Federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by the Privacy Rule.

I understand that I may revoke this Authorization in writing at any time, except to the extent that the organization obtaining the Authorization has already taken action in reliance on it, by contacting the Director of Health Information.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment or eligibility for benefits.

I understand that my refusal to sign this Authorization for the use or disclosure of health information for purposes of research may affect my ability to receive treatment related to the research.

I understand that Memorial Health may refuse to provide me with health care that is solely for the purpose of creating health information for disclosure to a third party if I refuse to sign this Authorization for the disclosure of health information to the third party.

Check Only if Applicable

☐ I understand that Memorial Health will receive compensation related to the use/disclosure of my health information under this Authorization.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____

Signature of Patient or Patient's Authorized Representative

Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

_____ _____

Name

Relationship to Patient

(A copy of this signed Authorization must be given to the representative.)

FOR OFFICE USE ONLY

AMD: _____

FS: _____ **LAB:** _____

DC: _____ **L&D:** _____

H&P: _____ **PATH:** _____

CONS: _____ **N.N:** _____

DR. ORD: _____ **EKG:** _____

PROG: _____ **OPD:** _____

X-RAY: _____ **ER:** _____

DATE: ____/____/____ **BY:** _____

Patient ID Area