RI0040

Hamilton Health Care System

1200 Memorial Drive
P.O. Box 1168
Dalton, Georgia 30722-1168

Ciox Health is a contracted release of information vendor for Hamilton Medical Center, Inc. and its covered entity Affiliates. Below are the standard fees for producing a copy of your medical records by Ciox Health.

Fees to receive copies of your medical records are as follows:

- $6.50 for records delivered electronically or for paper delivery and pick up
- $0.90 Labor
- $0.05 per page supply costs
- Any applicable postage (if mailed) and taxes

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee either in advance, when services are rendered, or when I receive an invoice from Ciox Health.

NAME:_____

PHONE #:_____

ADDRESS:_____

_____

_____

SIGNATURE: _____

DATE: _____

QUESTIONS: CALL 706-272-6345 for Hamilton Medical Center Locations
CALL 800-367-1500 for Hamilton Physician Group Locations

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AUTHORIZATION
FOR
DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Last 4 of Social Security #: _____

Phone Number: _____

I hereby authorize Hamilton Medical Center, Inc., together with its covered entity Affiliates and their employees, agents, medical staff and contractors (collectively "Hamilton"), to use or disclose the Patient's protected health information ("PHI") covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as specified in this Authorization. I understand that this Authorization is for use by Hamilton Medical Center and also Hamilton Medical Center's covered entity Affiliates.

I understand that PHI includes records disclosed to Hamilton by health care providers and facilities who previously provided treatment to the Patient. I also understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment, substance abuse treatment, privileged communications, genetic information, infectious or communicable diseases, or information relating to testing or treatment for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus).

Records from the following location(s) to be used or disclosed (check all that apply)**:**

Hamilton Medical Center, Inc.:

- ❑ Hamilton Medical Center
- ❑ Bradley Whiteside Rehab Center
- ❑ Cardiac Rehab
- ❑ Dr. Erick Kimmerling - Pulmonology
- ❑ Hamilton Diagnostic Center
- ❑ Hamilton Internal Medicine Clinic
- ❑ Hamilton Sleep Lab
- ❑ Hamilton Spine Health & Sport
- ❑ Hamilton Wound Care & Hyperbaric Ctr.
- ❑ Peeples Cancer Institute

Hamilton Physician Group, Inc.:

- ❑ Hamilton Convenient Care – Dalton
- ❑ Hamilton Convenient Care – Murray
- ❑ Hamilton Convenient Care – Varnell
- ❑ Hamilton Primary Care – Calhoun
- ❑ Hamilton Primary Care – Dalton
- ❑ Hamilton Primary Care – Murray
- ❑ Hamilton Physician Group – Behavioral Health
- ❑ Hamilton Physician Group – Cardiology
- ❑ Hamilton Physician Group – Catoosa Campus
- ❑ Hamilton Physician Group – Chattanooga Cardiology
- ❑ Hamilton Physician Group – Gastroenterology
- ❑ Hamilton Physician Group – General Surgery
- ❑ Hamilton Physician Group – Neurosurgery & Spine – Calhoun
- ❑ Hamilton Physician Group – Neurosurgery & Spine – Dalton
- ❑ Hamilton Physician Group – Neurology
- ❑ Hamilton Physician Group – Specialty Care

Originator: Health Information Management
Origination Date: October 2005
Revised Date: July 2021

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Information to be Used or Disclosed:

❑ Complete Medical Record, excluding all images

OR

The following selected items (check all that apply):

❑ Discharge Summary
❑ History and Physical Examination
❑ Consultation Reports
❑ Mental Health Care or Services
❑ Diagnosis, Treatment and/or Referral for Alcohol and/or Drug Abuse
❑ Photographs, Videotapes, Digital or Other Images
❑ Progress Notes
❑ Laboratory Tests
❑ X-ray Reports

Please specify date(s) of treatment:

_____

❑ Other (please specify):

_____

_____

Note: If Psychotherapy Notes are being authorized for disclosure, then a separate Authorization for Psychotherapy Notes needs to be signed.

Person(s) Authorized to Make the Use or Disclosure:

The following persons or class of persons are authorized to make the specified use or disclosure of this information: Hamilton Medical Center, Inc. and its covered entity Affiliates, as well as their employees, agents, medical staff and contractors.

Recipient(s) of Use or Disclosure (Indicate the person(s) or entity in which you wish to receive this information): This information may be used by or disclosed to the following persons or class of persons:

_____

_____

Purpose(s) of the Use or Disclosure:

A description of each purpose of the use or disclosure is as follows:

_____

_____

OR

❑ I am requesting the use or disclosure of the Patient's information pursuant to this Authorization, and the information will be used and disclosed at my request.

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Origination Date: October 2005
Revised Date: July 2021

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Expiration:

This Authorization will expire on the following date or event: _____
(or within one (1) year if no other date is specified); or

If this Authorization is for research purposes, it will expire

❑ At the end of the research study, or

❑ It will have no expiration date because the project provides for the creation and maintenance of a research database or research repository.

How to Revoke This Authorization

I understand I may revoke this Authorization by submitting a written revocation, on a form provided by Hamilton. **For Hamilton Medical Center locations** please submit to Hamilton Medical Center, Attention: Medical Records Department, P.O. Box 1168, Dalton, Georgia 30722-1168 or by facsimile at (706) 272-6049. I may obtain the revocation form by calling Hamilton Medical Center's Medical Records Department at (706) 272-6345. **For Hamilton Physician Group locations** please submit to Hamilton Physician Group, Attention: HPG Administration, P.O. Box 1587, Dalton, Georgia 30722-1587 or by facsimile at (706) 529-6017. I may obtain the revocation form by calling Ciox Health at (800) 367-1500. However, a submitted revocation shall not be effective with respect to any use or disclosure made by Hamilton in reliance on this Authorization prior to the date of Hamilton's receipt of my revocation.

Authorization as a Condition

I understand Hamilton cannot require me to sign this Authorization as part of treatment, payment, health plan enrollment or eligibility for benefits, except as otherwise permitted by HIPAA. If the provision of healthcare by Hamilton is solely for the purpose of creating PHI for disclosure to a third party (e.g., an employee physical exam) or is for research-related treatment, I understand that Hamilton will not provide the service unless I sign this Authorization.

Further Use

I understand that the Patient's PHI will not be further used or disclosed in exchange for remuneration (payment) to Hamilton, without a separate authorization.

Potential Redisclosure

I understand that the information used or disclosed by Hamilton pursuant to this Authorization may be subject to redisclosure by the recipient in which case it might no longer be protected under HIPAA. However, I understand that in some cases, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize Hamilton to copy this Authorization and to send the recipient the redisclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether or not the Patient's records contain information protected by those laws.

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[Hamilton to Complete the Following if Use or Disclosure involves Marketing or a Sale of PHI]

❑ The requested use or disclosure involves marketing or a sale of PHI under HIPAA.

Such use or disclosure ❑ will ❑ will not involve remuneration (payment) to Hamilton, whether directly or indirectly.

[Applicable for Research Authorization]

I understand that if this Authorization pertains to a research project, my right to obtain access to the Patient's PHI contained in a research database can be suspended for as long as the research project is in progress. I understand and agree to this temporary denial of access, and I understand that such right of access to PHI contained in the research database will be reinstated upon completion of the research. If the Patient is participating in a research study that requires the signing of this Authorization, I understand I can request additional information about (1) other research activities, if any, that do not require a signed authorization; and (2) the ability to opt in to such other research activities.

Unless my disagreement is initialed at the end of this sentence, I understand and agree that the Patient's PHI can be used or disclosed for future research consistent with HIPAA and that such PHI may include information collected after the end of the original study. _____ (Initials)

[Applicable if Authorization is Requested by Hamilton]

I understand that if this Authorization is being requested by Hamilton, I must be provided with a copy of the signed Authorization.

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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 authorized to permit release of records on the Patient's behalf. I hereby voluntarily release Hamilton Medical Center, Inc., its Affiliates, and their officers, trustees, employees, agents, medical staff and contractors from any liability, damages and expenses arising in connection with the use or disclosure of the Patient's protected health information pursuant to this Authorization. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

_____ _____

Print Patient Name Date

_____

Patient Signature

_____

Print Patient's Authorized Representative Name

_____

Signature of Patient's Authorized Representative

Basis of authority to sign for patient: _____

[Note: Copy of the signed Authorization to be provided to Patient]

Phone number for follow-up questions or notifications: _____

❑ **Please send my record via eDelivery. You will receive an email with instructions on how to access your records. My email address is: _____**

❑ **Please fax my health information to my healthcare provider. Faxing is restricted to continuity of care requests only. Fax number: _____**

❑ **I would like to pick up my health information in person. If someone other than yourself will be picking it up, please provide their name: _____**

❑ **Please send my health information by mail to:**

Name: _____

Mailing Address: _____

City, State, Zip: _____

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For Hamilton Physician Group locations please submit to Hamilton Physician Group, Attention: HPG Administration, P.O. Box 1587, Dalton, Georgia 30722-1587 or by facsimile at (706) 529-6017. For questions call (800) 367-1500.

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AUTHORIZATION FOR DISCLOSURE OF PSYCHOTHERAPY NOTES

Patient Name: _____ Date of Birth: _____

Address: _____ Last 4 of Social Security #: _____

_____ Phone Number: _____

I hereby authorize Hamilton Medical Center, Inc. together with its covered entity Affiliates, and their employees, agents, medical staff and contractors (collectively "Hamilton"), to use or disclose the above Patient's "Psychotherapy Notes" covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as specified in this Authorization. I understand the Psychotherapy Notes to be disclosed include records disclosed to health care providers and facilities which currently provide or previously provided treatment to the Patient. I also understand that "Psychotherapy Notes" may include information and records protected under Federal Law (such as regarding alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment, substance abuse treatment, privileged communications, genetic information, infectious or communicable diseases, or information relating to the testing or treatment for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus).

Records from the following location(s) to be used or disclosed (check all that apply)**:**

Hamilton Medical Center, Inc.:

- ❑ Hamilton Medical Center

Hamilton Physician Group, Inc.:

- ❑ Hamilton Physician Group – Behavioral Health

Information to be Used or Disclosed:
I understand that this Authorization applies to Psychotherapy Notes which are defined under HIPAA as follows: "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical record." 45 C.F.R. §164.501. I understand Psychotherapy Notes as defined under HIPAA do not include "medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." 45 C.F.R. §164.501.

Unless specified below, I authorize the release of a complete set of the Patient's Psychotherapy Notes:

- ❑ Other (please specify):

_____

Person(s) Authorized to Make the Use or Disclosure:
I hereby authorize Hamilton, as defined above, including any psychiatrist, psychologist, psychotherapist, mental health professional, physician or other practitioner of the healing arts who maintains the Patient's

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Psychotherapy Notes at, on behalf of or in connection with Hamilton, to release the Patient's Psychotherapy Notes as specified in this Authorization.

Recipient(s) of Use or Disclosure (Indicate the person(s) or entity in which you wish to receive this information): The Patient's Psychotherapy Notes may be used by or disclosed to the following:

_____

_____

If the recipient is an entity, then the Patient's Psychotherapy Notes may also be used by or disclosed to that entity's agents and employees.

Purpose(s) of the Use or Disclosure:
The purpose of the use or disclosure is to provide the Patient's Psychotherapy Notes at the request of the individual signed below.

Expiration
This Authorization will expire on the following date or event: _____ (or within one (1) year if no other date is specified); or

If this Authorization is for research purposes, it will expire

- ❑ At the end of the research study, or
- ❑ It will have no expiration date because the project provides for the creation and maintenance of a research database or research repository.

How To Revoke This Authorization
I understand I may revoke this Authorization by submitting a written revocation, on a form provided by Hamilton. **For Hamilton Medical Center locations** please submit to Hamilton Medical Center, Attention: Medical Records Department, P.O. Box 1168, Dalton, Georgia 30722-1168 or by facsimile at (706) 272-6049. I may obtain the revocation form by calling Hamilton Medical Center's Medical Records Department at (706) 272-6345. **For Hamilton Physician Group locations** please submit to Hamilton Physician Group, Attention: HPG Administration, P.O. Box 1587, Dalton, Georgia 30722-1587 or by facsimile at (706) 529-6017. I may obtain the revocation form by calling Ciox Health at (800) 367-1500. However, a submitted revocation shall not be effective with respect to any use or disclosure made by Hamilton in reliance on this Authorization prior to the date of Hamilton's receipt of my revocation.

Authorization as a Condition
I understand Hamilton cannot require me to sign this Authorization as part of treatment, payment, health plan enrollment or eligibility for benefits, except as otherwise permitted by HIPAA. If the provision of healthcare by Hamilton is solely for the purpose of creating PHI for disclosure to a third party (e.g., an employee physical exam) or is for research-related treatment, I understand that Hamilton will not provide the service unless I sign this Authorization.

Further Use
I understand that the Patient's Psychotherapy Notes will not be further used or disclosed in exchange for remuneration (payment) to Hamilton, without a separate authorization.

Potential Redisclosure
I understand that the Psychotherapy Notes used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient, in which case they might no longer be protected under HIPAA. However,

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I understand that in some cases, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize Hamilton to copy this Authorization and to send the recipient the redisclosure notice required under the Federal Substance Abuse Confidentiality Requirements, whether or not the Patient's records contain information protected by those laws.

[Hamilton to Complete the Following if Use or Disclosure involves Marketing or a Sale of PHI]

❑ The requested use or disclosure involves marketing or a sale of PHI under HIPAA.

Such use or disclosure ❑ will ❑ will not involve remuneration (payment) to Hamilton, whether directly or indirectly.

[Applicable for Research Authorization]
I understand that if this Authorization pertains to a research project, my right to obtain access to the Patient's protected health information ("PHI") contained in a research database can be suspended for as long as the research project is in progress. I understand and agree to this temporary denial of access, and I understand that the right of access to such PHI contained in the research database will be reinstated upon completion of the research. If the Patient is participating in a research study that requires the signing of this Authorization, I understand I can request additional information about (1) other research activities, if any, that do not require a signed authorization; and (2) the ability to opt in to such other research activities.

Unless my disagreement is initialed at the end of this sentence, I understand and agree that the Patient's PHI can be used or disclosed for future research consistent with HIPAA and that such PHI may include information collected after the end of the original study. _____ (Initials)

[Applicable if Authorization is Requested by Hamilton]

I understand that if this Authorization is being requested by Hamilton, I must be provided with a copy of the signed Authorization.

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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 authorized to permit release of records on the Patient's behalf. I hereby voluntarily release Hamilton Medical Center, Inc., its Affiliates, and their officers, trustees, employees, agents, medical staff and contractors from any liability, damages and expenses arising in connection with the use or disclosure of the Patient's protected health information pursuant to this Authorization. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

_____ _____

Print Patient Name Date

_____

Patient Signature

_____

Print Patient's Authorized Representative Name

_____

Signature of Patient's Authorized Representative

Basis of authority to sign for patient: _____

[Note: Copy of the signed Authorization to be provided to Patient]

Phone number for follow-up questions or notifications: _____

❑ **Please send my record via eDelivery. You will receive an email with instructions on how to access your records. My email address is:** _____

❑ **Please fax my health information to my healthcare provider. Faxing is restricted to continuity of care requests only. Fax number:** _____

❑ **I would like to pick up my health information in person. If someone other than yourself will be picking it up, please provide their name:** _____

❑ **Please send my health information by mail to:**

Name: _____

Mailing Address: _____

City, State, Zip: _____

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I understand I may revoke a prior Authorization by submitting a written revocation on the form provided below. However, a submitted revocation shall not be effective with respect to any use or disclosure made by Hamilton in reliance on this Authorization prior to the date of Hamilton's receipt of my revocation.

REVOCATION OF AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Last 4 of Social Security #: _____

Address: _____

_____

I hereby revoke the Authorization that I previously granted to Hamilton Medical Center and/or covered entity Affiliates ("Hamilton") to use or disclose my protected health information for the purpose of:

_____

I understand that this Revocation shall not be effective with respect to any use or disclosure made by Hamilton in reliance on the Authorization prior to the date that Hamilton receives this Revocation.

_____ _____
Print Patient Name Date

_____
Patient Signature

_____
Print Patient's Authorized Representative Name

_____
Signature of Patient's Authorized Representative

Basis of authority to sign for patient: _____
[Note: Copy of the signed Revocation to be provided to Patient]

For Hamilton Medical Center locations please submit to Hamilton Medical Center, Attention: Medical Records Department, P.O. Box 1168, Dalton, Georgia 30722-1168 or by facsimile at (706) 272-6049.

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