

LAKEVIEW BEHAVIORAL HEALTH HOSPITAL

Medical Records Authorization Instructions

To obtain a copy of your medical records, please complete and sign an Authorization for Release of Information (ROI) form.

Submit Completed Authorizations

Fax: 770-446-7016

Email: medical.records@lakeviewbehavioralhealth.com

Mail: Lakeview Behavioral Health Hospital, Attn: HIM Department, 1 Innovation Dr
Norcross, GA 30092

Required Information

- Patient Full Name
- Date of Birth
- Dates of Treatment (if known)
- Specific Records Requested
- Recipient Name and Contact Information
- Purpose of Disclosure (if applicable)
- Patient Signature
- Date Signed

HIPAA Authorization Requirements

Under HIPAA, the authorization must identify the patient, information to be disclosed, disclosing party, recipient, purpose, expiration date/event, and patient signature/date.

Patient Rights

- You may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance upon it.
- Treatment, payment, enrollment, or eligibility for benefits is generally not conditioned on signing this authorization.
- Information released under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy laws.
- You may request a copy of your signed authorization.

Authorization Statement

I hereby authorize Lakeview Behavioral Health Hospital to release the protected health information described in my Authorization for Release of Information. I understand that I may revoke this authorization at any time by providing written notice, except to the extent action has already been taken in reliance on it. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Questions?

Phone: 678-743-1968

Fax: 770-446-7016

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