CARILION CLINIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ (Print Full Name) do hereby authorize and request CRRVMC (Name of Health Care Entity) to release and disclose protected health information of: _____ (Patient Name)

Patient / Requester Address

Patient's Address: _____

Date of Birth: _____

Social Security # _____

Phone#: _____

To the Following Person, Agency or Health Care Entity:

Name: _____

Address: _____

Please specify the Protected Health Information to be released by marking the following:

Are you requesting psychotherapy notes? ☐ Yes, then you may only request psychotherapy notes on this authorization. You must submit a separate authorization for other items. ☐ No, then you may check as many items below as you need.

☐ Discharge Summary	☐ History & Physical	☐ Operative Path Report
☐ Complete Record	☐ Radiology Reports / Films	☐ Emergency / Outpatient
☐ _____ Other (Specify)	☐ Lab Reports	☐ EKG / EEG / ECHO / Stress
		☐ _____ Treatment Date(s) Requested

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric treatment, sexually transmitted disease treatment, HIV testing, HIV results or AIDS information. _____ (Initial)

The Purpose of this disclosure is for: _____ Medical Care, _____ Changing PCP/Family Physician, _____ Changing Specialists, _____ Insurance Processing, _____ Legal, _____ at the request of the individual, _____ Other (Specify)

I understand that:

- By signing this Authorization, I am giving the Health Care Entity permission to disclose confidential health records.
- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.
- I may withdraw (revoke) this Authorization in writing. Withdrawal of this Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice of revocation by the custodian of the health records.
- There is a potential that information disclosed may be redisclosed by the recipient and no longer protected by law.
- A copy of this Authorization and a notation concerning the person or agencies to which disclosure was made shall be included with the original health records.
- This Authorization will automatically expire one year after the day below OR on _____.
- A fee may apply to copies of PHI that I receive. I may ask for a cost estimation/invoice prior to the information being copied.

SIGNATURE: _____ (Signature of Patient / Legally Authorized Representative) DATE: _____ (specify date)

_____ (Relationship to Patient / Description of Authority to Act)

_____ (Address and Telephone Number of Legally Authorized Representative)

_____ (Signature of Witness) DATE: _____

HIM Employee Verified Identification of Requestor _____ (Initial)

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

CHART-0540 Org. 6/03 Rev. 7/10

FAX 731-2607

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