AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Telephone: ( ) _____ Email Address: _____

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for E-mail with Patients, posted on atriumhealth.org.

Release Information From:

_____
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:

_____
(Name of facility, person, company) (Relationship)

_____
(Street Address or PO Box, City, State, Zip Code)

_____
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal rep ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐Other_____

Fill in dates of treatment for records to be released:
Treatment dates: From _____ **To** _____

Facility (check all that may apply):
☐ Facility Summary – includes items in bold
☐ **Discharge Summary** ☐ **Emergency Record**
☐ **History and Physical** ☐ **Cardiac Reports/EKG**
☐ **Consultation reports** ☐ Other _____
☐ Assessment _____
☐ **Operative Reports** _ _____
☐ **Laboratory reports**
☐ **Radiology/X-Ray Reports**
☐ **Pathology reports**

☐ Entire record
☐ Itemized Bill

Office/Clinic/Home Care (check all that may apply):
☐ Office/Clinical Summary – includes items in bold
☐ **Office/Home Visits**
☐ **Physical Exam**
☐ **Laboratory Reports**
☐ **Radiology Reports**
☐ Therapy Notes
☐ Immunization Records
☐ Other_____
_____

☐ Entire Record
☐ Itemized Bill

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other_____

DELIVERY METHOD:
☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. Records protected by 42 CFR Part 2 may not be redisclosed without my additional consent**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **Atrium Health will not share or use my health information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at atriumhealth.org.**
- **I have a right to a copy of this Authorization.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:**_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written proof MAY be requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor:_____ **Print Name:** _____ **Date:** _____

Date of release:_____via ☐Mail ☐Fax ☐Other_____☐**ID Verified** ☐**DL/Other ID**_____
Atrium Health Teammate Name & Department. : _____ **Date:**_____ **# of Pages**_____

Rev. June 2019

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Place Patient Label Here