Attachment A
PR.PHI 140.05

One Patient Per Authorization Form **There may be a charge for record copies**

Carolinas HealthCare System - Authorization for Release of Health Information Form

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations once it is disclosed.

PURPOSE OF RELEASE: ❑Ongoing Communication ❑Copy of Record ❑Legal or Insurance Review ❑Authorized Representative's Request
❑ Other _____

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information:
Facility/Practice Name: _____ **Telephone #:** _____
Facility/Practice Address: _____ **Fax #**_____

DATES OF SERVICE, RANGE OF TIME OR EVENT(S The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or events(s):
From: (MM/DD/YY) _____ To: (MM/DD/YY) _____
This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ **All Records & Details** ❑ **Other (Please Specify)** _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ _____ _____
First Middle/Maiden Last

Patient Address: _____
(Street Address/PO Box, City, State, Zip)

Social Security #: _____**Date of Birth**: _____ **Medical Record/Chart #**_____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ **Work:** _____ **Cell:** _____

Please provide email address where you are authorizing CHS to leave patient information as described above. By providing your email address you agree that you have read and agree to the "Guidelines for email with patients" posted on www.carolinashealthcare.org
Email Address:_____

RELEASE TO This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____
SIGNATURE: _____ **DATE:**_____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, 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.
NAME OF MINOR: _____**SIGNATURE OF MINOR**: _____ **DATE**: _____

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No ❑ N/A❑ Identification verified ❑ Copy of Authorization given to patient / Date of release:_____via ❑Mail ❑Fax ❑Other_____
❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____
_____

CHS Employee Name & Title: _____**CHS Employee Signature:** _____**Date** _____ **Rev. 09/17/08**