

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)
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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): <input type="checkbox"/> Facility Summary – includes items in bold <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> History and Physical <input type="checkbox"/> Cardiac Reports/EKG <input type="checkbox"/> Consultation reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Assessment _____ <input type="checkbox"/> Operative Reports _____ <input type="checkbox"/> Laboratory reports _____ <input type="checkbox"/> Radiology/X-Ray Reports _____ <input type="checkbox"/> Pathology reports _____ <input type="checkbox"/> Entire record <input type="checkbox"/> Itemized Bill	Office/Clinic/Home Care (check all that may apply): <input type="checkbox"/> Office/Clinical Summary – includes items in bold <input type="checkbox"/> Office/Home Visits <input type="checkbox"/> Physical Exam <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Immunization Records <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire Record <input type="checkbox"/> Itemized Bill
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FORMAT: <input type="checkbox"/> CD (charges may apply) <input type="checkbox"/> Email Address noted above, where permitted <input type="checkbox"/> Paper copy (charges may apply) <input type="checkbox"/> Other _____	DELIVERY METHOD: <input type="checkbox"/> Reg.US Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax, where permitted <input type="checkbox"/> Overnight/Express Mail Service, where permitted <input type="checkbox"/> Secure email <input type="checkbox"/> Other: _____
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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 _____

