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

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

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 carolinashealthcare.org.

Release Information From:	**Release Information To:**
_____ (List applicable Facility(s) and/or Practice(s))	_____ (Name of facility, person, company)
_____	_____ (Street Address or PO Box, City, State, Zip Code)
_____ (Phone number) (Fax number)	_____ (Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ 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 Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinical Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Facility (check all that may apply):	**Office/Clinic/Home Care (check all that may apply):**	**Behavioral Health/Sub. Use (check all that may apply):**
☐ Facility Summary	☐ Office/Clinical Summary	☐ Facility Summary
☐ Discharge Summary ☐ Emergency Record	☐ Office/Home Visits	☐ Clinical/Discharge Summary
☐ History and Physical ☐ Cardiac Reports/EKG	☐ Physical Exam	☐ Assessments
☐ Consultation reports ☐ Other_____	☐ Laboratory Reports	☐ Physician Orders
☐ Operative Reports _____	☐ Radiology Reports	☐ Progress/Therapy Notes
☐ Laboratory reports _____	☐ Other_____	☐ Medications
☐ Radiology/X-Ray Reports _____	_____	☐ Lab reports
☐ Pathology reports _____	☐ Entire Record (Not including psychotherapy notes)	☐ Other _____
☐ Entire record (Not including psychotherapy notes)	☐ Itemized Bill	☐ Entire Record (Not including psychotherapy notes)
☐ Itemized Bill		☐ Itemized Bill

FORMAT:	**DELIVERY METHOD:**
☐ CD (charges may apply)	☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Email Address noted above, where permitted	☐ Overnight/Express Mail Service, where permitted
☐ Paper copy (charges may apply)	☐ Secure email
☐ Other_____	☐ 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.**
- **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 Atrium Health's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**

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:** _____

Authorization given to patient / Date of release: _____ via ☐Mail ☐Fax ☐Other_____ ☐ID Verified ☐DL/Other ID_____
Employee Name: _____ **Date:** _____

Atrium Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information or Sticker

Name:
DOB:
Medical Record #: **Account #:**