AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:	Date of Birth:
Street Address:	Last 4 of SSN:
City, State, Zip:	Phone: ( )
E-mail:	

RELEASE FROM (check all that apply):	**RELEASE TO:**
□ Monarch (all locations, ***except*** those listed below)	Name of Individual:
□ Stanly Industrial Services (BH Stanly)	Name of Organization:
□ Tanglewood Arbor	Street Address or P.O. Box:
	City, State, Zip:
	Fax:
	E-mail:

REASON FOR RELEASE (check all that apply):

□ Personal □ Legal □ Continued Patient Care
□ Insurance □ Personal Injury/Social Security □ Workers' Compensation
□ Other (specify):

DATES OF RECORDS TO RELEASE (check one):

□ All Dates □ From ____/____/_____ to ____/____/_____

WHAT TO RELEASE (check all that apply):

□ All Records (not including psychotherapy notes) □ Comprehensive Clinical Assessments □ Dates/Times/Locations of Treatment
□ Discharge Summaries □ Medication Reports □ Service Notes
□ Other (specify):

DELIVERY METHOD (charges may apply):

□ U.S. Mail □ Encrypted E-mail (this may require setting up an account) □ Fax
□ Other (specify):

I understand that:

- I can cancel this authorization at any time. I must cancel in writing and send or deliver the cancellation to Monarch. Any cancellation will apply only to information not yet released by Monarch.
- 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, unless limited by the above selections.
- 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.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

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

If you are requesting your own records:	**If you are requesting records on behalf of another person:**
Signature:	Signature:
Print Name:	Print Name:
Date:	Date:
	Relationship to Patient (written proof may be required): □ Parent/Guardian □ Executor/Administrator □ Healthcare Agent □ Other (specify):

Please mail completed Authorizations to Monarch's Administrative Office (350 Pee Dee Avenue, Suite 101, Albemarle, NC 28001), send them to Monarch's Medical Records Department via e-mail (medicalrecordsrequest@monarchnc.org; please note that unencrypted e-mail may not be secure) or via fax ((844) 892-3419), or drop them off at any Monarch location.