FirstHealth OF THE CAROLINAS

8181.99.15009.04 Sunset Date: 5/2024

Place Patient Label Inside This Box

Authorization for Release of Information

1ROI001

INSTRUCTIONS FOR COMPLETING FORM: Please write legibly and complete all sections **including witness signature** as indicated *(SS # optional)*. Return the completed and signed form to: **Health Information Management, Release of Information PO Box 3000, Pinehurst, NC 28374**

*** * Please complete all parts of the form to include signature, date and time. * ***

PART A

Patient Name: Date of Birth:

Address: City: State: Zip:

Phone: SS# (last 4 digits): Email:

PART B: PERSON OR ENTITY WHO WILL RECEIVE INFORMATION *(select one)*

☐ Self (Same info as above) ☐ Other Person/Entity:

Address: City: State: Zip:

Phone: Fax:

PART C: INFORMATION TO BE RELEASED (Check all that apply)

☐ Abstract/Summary (Discharge Summary, Operative/Procedure Notes, Pathology, Laboratory, ED Notes, Clinic Visits, Consults).
☐ Entire Record
☐ Discharge Summary
☐ History and Physical
☐ Consultation Report
☐ Operative Report
☐ Emergency Department record
☐ Laboratory Reports
☐ Pathology Reports
☐ Radiology Reports
☐ Clinic Note
☐ Other: _____

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable disease, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):

☐ Mental and Behavioral Health ☐ Alcohol and/or Drug Use Disorder ☐ AIDS and/or HIV Diagnosis ☐ Psychotherapy Notes

Treatment Location:

☐ All FirstHealth Entities ☐ Moore Regional Hospital ☐ Moore Regional Hoke Campus ☐ Moore Regional Richmond Campus ☐ Montgomery Campus

☐ Clinic (Specify Provider/Clinic): _____ ☐ Other: _____

Treatment Date(s): From: _____ to _____ (Please be specific)

PART D: PURPOSE OF REQUEST: ☐ Personal ☐ Legal ☐ Insurance ☐ Continuation of Care ☐ Other: _____

PART E: FORMAT AND DELIVERY OF INFORMATION

Format *(select only one)*

☐ Electronic (MyChart) ☐ CD ☐ Paper ☐ Fax **(Healthcare Providers ONLY)**

Delivery Method *(select only one for CD or Paper Format)*

☐ Mail ☐ In Person Pick up: Name: _____

PART F: REVIEW AND APPROVAL

I understand that this authorization is voluntary and that I may refuse to sign it. I need not sign this form to ensure healthcare treatment or payment for such treatment. This authorization is void in 180 days after the date signed or anytime I, as the patient, guardian, or legally authorized representative make a **specific written request to the entity noted above to revoke** the authorization. Such revocation shall be effective except to the extent that the facility has already used or disclosed information in reliance on the authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law.

Alcohol and substance abuse records are protected by Federal Confidentiality Rules (42 CFR part 2). The Federal Rules prohibit any further disclosure of such records unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for re-disclosure of protected records. The Federal Rules also restrict any use of the information to criminally investigate or prosecute any alcohol or substance abuse patient.

_____ _____ _____

Signature of Patient/* Individual With Legal Authority to Sign** **Date:** **Time:**

_____ _____ _____

Signature of Witness: **Date:** **Time:**

If you are not the patient or the parent of a minor patient, you MUST attach documentation of your authority to act on behalf of the patient (i.e. Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator).

****** THE FOLLOWING SECTION MUST BE COMPLETED WHENEVER PATIENT IS UNABLE TO PERSONALLY SIGN FOR RELEASE OF PROTECTED HEALTH INFORMATION***

Patient is unable to authorize release of records/information as a result of the following (check one):

☐ Patient is a minor, ☐ Patient is mentally incompetent, ☐ Patient has a physical disability that prohibits signing or

☐ Deceased/Other (clearly state reason if other) _____

NOTE: If the patient is deceased, only the executor and/or administrator of the estate or next-of-kin may authorize release of copies of medical records. Documentation reflecting such individual's legal authority to sign for release of records must be provided.