AUTHORIZATION TO RELEASE HEALTH INFORMATION

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**

Printed Patient Name (Last, First, Middle Initial)	Birth Date (MM/DD/YYYY)	Social Security Number	MR# -Internal Use

Mailing Address (Include Street/PO Box, City and Zip Code)	Telephone# (Including Area Code) ( )

Date/s of Treatment Covered Under Request	Date Copies Needed By	Mail ☐ Pick-up ☐ (Positive ID Required)

I hereby authorize: ☐ **FirstHealth** – _____

☐ _____

to release copies of records on the above patient to ☐ myself ☐ Other ATTN: _____

ADDRESS _____

(*Indicate complete mailing address if different from patient address).*

PHONE NUMBER _____ **FAX NUMBER** _____

INFORMATION TO BE RELEASED INCLUDES (*Check applicable box/s and indicate other information in the space below. Please also be aware that you may be charged for any records copied*):

☐ ED Physician Report	☐ Operative Report/s	☐ EKG Report/s	☐ Abstract (All MD dictations & diagnostics)
☐ History and Physical	☐ Pathology Report/s	☐ X-ray Report(s)	☐ Complete Record
☐ Discharge Summary	☐ Laboratory Report/s	☐ X-ray Films	☐ Record Review Request
☐ Consultation Report/s	☐ Other _____		

BY INITIALING BELOW, I further authorize release of information that may be present in my record to include information related:

_____ Alcohol or drug abuse, _____ Mental or behavioral health or psychiatric care,

_____ AIDS and/or HIV diagnoses _____ Psychotherapy session notes and records

PURPOSE OF RELEASE _____

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 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 once information is used or disclosed based on this authorization it may be re-disclosed by the recipient and at such time may no longer be protected by federal privacy laws or regulations.

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

******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 individuals' legal authority to sign for release of records must be provided.

FirstHealth OF THE CAROLINAS

Authorization to Release Health Information

Original: Patient Chart

1ROI001

Place Patient Label Inside This Box

8181.99.15009.03.fhc Sunset Date: 11/2019