

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:
(List applicable Facility(s) and/or Practice(s))
(PHONE NUMBER) (FAX NUMBER)

Release Information To:
(Name of facility, person, company)
(Street Address or PO Box, City, State, Zip Code)
(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):
Facility Summary
Discharge Summary
History and Physical
Consultation reports
Operative Reports
Laboratory reports
Radiology/X-Ray Reports
Pathology reports
Entire record (Not including psychotherapy notes)
Itemized Bill

Office/Clinic/Home Care (check all that may apply):
Office/Clinical Summary
Office/Home Visits
Physical Exam
Laboratory Reports
Radiology Reports
Other
Entire Record (Not including psychotherapy notes)
Itemized Bill

Behavioral Health/Sub. Use (check all that may apply):
Facility Summary
Clinical/Discharge Summary
Assessments
Physician Orders
Progress/Therapy Notes
Medications
Lab reports
Other
Entire Record (Not including psychotherapy notes)
Itemized Bill

FORMAT:
CD (charges may apply)
Email Address noted above, where permitted
Paper copy (charges may apply)
Other

DELIVERY METHOD:
Reg.US Mail Pick-up Fax, where permitted
Overnight/Express Mail Service, where permitted
Secure email
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.
CHS will not share or use my health information without my permission other than by ways listed in CHS'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: _____



Patient Information or Sticker

Name:
DOB:
Medical Record #:

Account #: