CARILION CLINIC

Authorization to Release Protected Health Information

Patient's Full Name ____________________	*Date of Birth* __________
Street Address ____________________	*Phone (Home or Cell)* __________
City, State, Zip Code ____________________	*Phone (Work)* __________

A fee may apply to copies of protected health information that I request, whether received by me or by another recipient I authorize. I may ask for a cost estimation / invoice prior to the information being copied. Fees are charged as state and federal laws allow.

I, ______________________________ hereby authorize Carilion Clinic
(Patient or Legal Representative)

☐ Carilion Clinic *(All Facilities)*
☐ Carilion Roanoke Memorial Hospital
☐ Carilion Roanoke Community Hospital
☐ Carilion Franklin Memorial
☐ Carilion Giles Community Hospital
☐ Carilion New River Valley Medical Center
☐ Carilion Rockbridge Community Hospital
☐ Carilion Tazewell Community Hospital
☐ Carilion Clinic Physician's Office or Provider: ____________________
(Specify Carilion Office or Provider)

or ______________________________ to release copies of medical records:
(Other Health Care Provider)

DATE(S) OF MEDICAL SERVICE: ______________________________

☐ PERTINENT ELEMENTS ONLY (Most Recent Discharge Summary, History & Physical, and Operative Notes)
☐ History & Physical
☐ Discharge Summary
☐ Operative / Procedure Reports
☐ Immunization Record
☐ Cardiac / Heart Studies
☐ Lab / Pathology Reports
☐ X-Ray / Imaging Reports
☐ X-Ray / Imaging Film / CD
☐ Emergency Room Record
☐ Psychiatric Record
☐ Other: *(Specify)* ______________________________

METHOD OF DELIVERY: ☐ Print / Paper ☐ MyChart ☐ CD
☐ Other: *(Specify)* ______________________________

***MyChart is Carilion Clinic's secure patient portal and preferred method of communication with patients. If you request that we email your records to you or to your personal representative using standard (unencrypted) email, please understand that this is not a secure form of transmission and your protected health information may be intercepted by third parties during transmission. Carilion Clinic cannot be held responsible for records sent through unsecure communication methods.**

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric treatment, sexually transmitted disease treatment, HIV testing, HIV results or AIDS information. _____ *(initial)*

CARILION CLINIC

CMC - CRMH CMC - CRCH CFMH CGCH CNRV CRBH CTCH

PATIENT IDENTIFICATION

CARILION CLINIC

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The purpose of this disclosure is for: ☐ Medical Care ☐ Changing Physician ☐ Insurance Processing ☐ Legal ☐ Personal ☐ Other *(Specify)* ______________________

RELEASE INFORMATION / MEDICAL RECORDS TO:

____

Name (Patient, Physician, Hospital, Agency, etc.)

______________________________ ______________

Street Address *Phone*

______________________________ ______________

City, State, Zip Code *Fax*

I understand that:

- By signing this Authorization, I am giving the Health Care Entity permission to disclose confidential health records.
- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.
- I may withdraw (revoke) this Authorization in writing. Withdrawal of this Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice of revocation by the custodian of the health records.
- There is a potential that information disclosed may be redisclosed by the recipient and no longer protected by law.
- A copy of this Authorization and a notation concerning the person or agencies to which disclosure was made shall be included with the original health records.
- This Authorization will automatically expire one year after the day below OR on ______________________.
- If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

______________________________ ______________

Signature of Patient or Patient's Legal Representative *Date Signed*

____

Relationship to Patient / Description of Authority to Act

______________________________ ______________

Signature of Witness *Date Signed*

HIM Employee Verified Identification of Requestor _____ (initial)

Documentation Collected by Staff (OFFICE USE ONLY):
☐ Guardianship / Custody Papers ☐ Death Certificate ☐ Advance Directive ☐ Medical POA/General POA
☐ Executor of Estate Papers ☐ Other: ______________________________

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information 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.

PATIENT IDENTIFICATION