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 ☐ Immunization Record ☐ X-Ray / Imaging Reports ☐ Psychiatric Record
☐ Discharge Summary ☐ Cardiac / Heart Studies ☐ X-Ray / Imaging Film / CD
☐ Operative / Procedure Reports ☐ Lab / Pathology Reports ☐ Emergency Room 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)*

PATIENT IDENTIFICATION

Authorization to Release Protected Health Information

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