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Patient Name: _____DOB:_____MR#_____

I hereby authorize CaroMont Health to:

_____release medical records (protected health information) to (specify person/organization and address below); or,
_____obtain medical records (protected health information) from: (specify person/organization and address below).

Name:_____

Address:_____

I understand that the medical records, which I have requested to be released, may contain information regarding mental illness, HIV/AIDS and/or substance abuse (drugs and/or alcohol). I further understand my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse, 42 CFR Part 2, and cannot be disclosed without my written consent (as stated below) unless otherwise provided for in the regulations.

I ____ do ____ do not authorize release of information related to AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infections.
I ____ do ____ do not authorize release of information related to psychiatric care and/or psychological assessment.
I ____ do ____ do not authorize release of information related to treatment for alcohol and/or drug abuse.

Information to be Disclosed: (please check the appropriate box or boxes below)

Date(s) of Service: _____

____ Abstract (Discharge Summary, History/Physical, Consultation Reports, Operative Reports, Labs, Radiology, Pathology Report, EKG's)

____ Entire Record ____Discharge Summary ____History & Physical ____Consultation Reports

____Autopsy Reports ____Physician Orders ____Physician Progress Notes ____Pathology Report

____Nursing Data/Notes ____Radiology Reports ____Laboratory Results ____ER Record

____Operative Reports ____Other (please specify)_____

Purpose of Disclosure: The above information is released for the following purpose (please check the appropriate box or boxes listed below) and that purpose only. Any other disclosure is prohibited without my specific written authorization.

____Transfer Medical Care to (Doctor's Name): _____ ____Personal Use/Individual's Request

____Physician Request ____Insurance Use ____Other (please specify):

____Legal/Attorney Use ____Child/Adult Protective Services _____

I hereby acknowledge this authorization is voluntary and is valid until such request is fulfilled but not to exceed 90 days from the date signed. I release, discharge and agree to hold harmless all parties to whom this authorization is given from any liability that may arise from the release of information authorized above. I may revoke this request, in writing, at any time except to the extent that action based on this authorization has taken place. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I understand I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations

If I am requesting access to or authorizing release of medical records for a minor patient, I certify that I have legal authority to access or authorize release of the minor patient's medical records.

_____ _____
Signature of Patient or Authorized Legal Representative Relationship of Authorized Representative to Patient

_____ _____ _____ _____
Date Time AM/PM Witness (CaroMont Health employee is acceptable)

Fees: **$10.00 pages 1-14**
+ 0.75 pages 15-25
+ 0.50 pages 26-100
+ 0.25 pages 101

Patient or Authorized Legal Representative identification verified by one of the following:
____ Drivers' License / Other Photo ID
____ Signature on File in Medical Record
Employee Initials: _____ (Do not copy photo identification)

Authorization for the Release of Health Information

Tab: Miscellaneous
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Revision Date: 03/2013

CaroMont Health

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