Authorization to Release Protected Health Information

Patient Information: **(One Patient Per Form)**

Patient Name:_____ Date of Birth: _____

Street Address:_____ City, State, Zip: _____

Telephone:_____ Email:_____

Treatment Facility/Physician: _____

Treatment Dates: _____

☐ Check here if Information will be mutually exchanged (allows both the sender and recipient(s) to share the information below with each other) this is for Behavioral Health information only.

Information Requested (select all that apply):

Medical Records

☐ Facility Summary (includes all items in **bold**)
☐ **Discharge Summary**
☐ **History & Physical**
☐ **Consultation Reports**
☐ **Office/Progress Notes**
☐ **Emergency Record**
☐ **Operative Reports**
☐ **Laboratory Reports**
☐ **Pathology Reports**
☐ **Radiology Reports**
☐ **Immunizations**
☐ Sleep Study Reports
☐ Entire Medical Record
☐ Other: _____

Behavioral Health

☐ Treatment Records (Treatment Plans & Notes, Assessment, Psych Eval, Labs, Medications)
☐ Psychological Test Results
☐ Legal Status/Court Records

Imaging (requires CD format)

☐ Radiology Images (X-Ray/CT/MRI/US)
☐ Cardiology Images (Echo/Cath Lab)
☐ Neurology Images (EEGs)
☐ Fetal Ultrasound Images
☐ Other Imaging: _____

Billing

☐ Itemized Bill(s)
☐ UB04 Form
☐ CMS 1500 Form
☐ Other Billing: _____

Release the Requested Information to:

_____
(Name of Facility, Person, Company) (Street Address or PO Box, City, State, ZIP Code)

_____
(Phone Number) (Fax Number) (Email Address)

Purpose of Release:

☐ Continuation of Care ☐ Personal (at my request) ☐ Legal/Investigation ☐ Insurance ☐ Other: _____

Requested Format/Delivery Method: ***(Fees may apply)***

By Mail:
☐ Paper Copy
☐ CD

Electronically:
☐ Encrypted Email
☐ Patient Portal

Other:
☐ In Person Pick-up at: _____
☐ Paper ☐ CD

Your Rights Regarding This Authorization: I may revoke this authorization at any time by providing written notice to the health information department. Any revocation will apply only to information that has not yet been released. I have the right to inspect and receive a copy of this authorization. Refusing to sign this form will not affect my ability to receive treatment, payment, health plan enrollment, or eligibility for benefits. I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by federal and state privacy laws. 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.

Expiration: This authorization expires one year from the date of my signature unless otherwise written here: _____

Signature:_____ Print Name:_____ Date:_____

Relationship to Patient: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign; however, supporting documentation may be required. **Minor Authorization:** If a minor consented to treatment by a licensed physician for pregnancy, sexually transmitted diseases, outpatient behavioral or mental health care, or outpatient treatment for controlled substances or alcohol without parental consent, the minor may sign this authorization. If the minor is receiving substance use disorder treatment with parental or guardian consent, both the minor and the parent or guardian may sign this authorization.

Signature of Minor:_____ Print Name:_____ Date: _____

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Atrium Health

Place Patient Label Here