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 Roanoke Memorial Hospital
- ○ Carilion Roanoke Community Hospital
- ○ Carilion New River Valley Medical Center
- ○ Carilion Franklin Memorial
- ○ Carilion Stonewall Jackson Hospital
- ○ Carilion Giles Community Hospital
- ○ Carilion Tazewell Commun Hospital
- ○ Carilion Clinic (All Facilities
- ○ 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 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)

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).
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 ___ Medical POA/General POA

___ Death Certificate ___ Executor of Estate Papers

___ Advance Directive

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.