Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____ MR#: _____

Pt Address: _____ Pt Phone:_____ Pt SSN: _____

Authorization: I request and authorize the following entity/person to release and/or obtain health information to/from: (choose one)

☐ Coastal Carolina Health Care (CCHC):_____ OR ☐ Other Facility or Person:_____
_____ Contact Name/Phone: _____

Records requested **FROM: (Authorized to Disclose)**	Records to be **SENT TO: (Authorized to Receive)**
Facility/Individual: _____	Facility/Individual: _____
Address: _____	Address: _____
City/State/Zip_____	City/State/Zip_____
Phone #: _____	Phone #: _____
Fax Number: _____	Fax Number: _____

This information will cover the period(s) of healthcare From _____ To _____.
(Check information to be disclosed/released)

☐Office Visit Notes ☐Consultation Notes ☐Lab Results ☐Diagnostic Reports ☐Procedure Reports ☐Radiology Reports

☐Billing Information ☐CD Diagnostic Images ☐ Immunizations ☐Other (please specify): _____

Purpose: ☐Continuity of Care ☐Request of the Individual ☐Transfer of Care ☐Legal/Insurance ☐Other: _____

Purpose is not required if patient is obtaining a copy of the record for his/herself.

Format to be sent: ☐Electronically: via CD ($6.50 charge) ☐Paper ($6.50 charge)

☐Email Address (no charge) _____. I understand sending email over the internet is not secure. I understand there is a possibility that information included in an email can be intercepted and read by others beside the person whom it is addressed. I have been informed of the risks and still wish the information to be provided via email to the address noted.

☐Portal (Patient can view, download, and print information from their personal health record at their discretion**)**

****There is no charge for sending patient information to another healthcare provider, regardless of format chosen.**

Provide information by: ☐Fax to the number noted above ☐Mail/Email to the address noted above ☐Call for pick up

I understand that I may revoke this Authorization at any time. The revocation will not apply to information that has already been released in response to this Authorization or to my insurance company. If I revoke this Authorization, I must do so in writing and submit my revocation to my provider's office. If I have further questions, I may contact CCHC Privacy Officer. Phone (252) 514-6685, e-mail: privacy@cchealthcare.com

Unless otherwise revoked, this authorization will expire in: ☐**90 days;** ☐ **one year;** ☐**other: (cannot exceed one year)** _____.
If I fail to specify an expiration date, this authorization will expire one year from the date on which it was signed.

I understand authorizing the use or disclosure of the information identified above is voluntary and CCHC may not condition my treatment on my refusal to sign this authorization. **Content and Protection of Authorization**: I understand information released may include sensitive information related to behavioral and/or mental health records, drugs and alcohol, pregnancy, HIV/AIDS and other communicable diseases, cancer related illnesses and genetic testing. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
All requests will be handled within 30 days.

Patient or Representative Signature: _____ Date: _____

Printed Patient's Name: _____

Printed Representative's Name: _____ Relationship to Patient: _____

*Description of Personal Representative's Authority (attach necessary documentation) _____

CCHC's Representative Signature (Witness): _____ Date: _____