

Patient Name: _____ Date of Birth: _____
Street Address: _____ Last 4 numbers of SSN: _____
City, State, Zip: _____ Telephone: () _____
Email address: _____

Release Information From: _____
(List applicable Facility(s) and/or Practice(s))
Release Information To: _____
(Name of facility, person, company) (Relationship)
(Street Address or PO Box, City, State, Zip Code)
(Phone number) (Fax number) (Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): Request of individual/personal Continued patient care Insurance
 Legal purpose including discussions & proceedings Other

Fill in dates of treatment for records to be released:
Treatment dates: From _____ To _____

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply): Hospital Summary Discharge Summary History and Physical Consultation reports Operative Reports Laboratory reports Radiology/X-Ray Reports Pathology reports
Office/Clinic (check all that may apply): Office/Clinic Summary Office Visits Physical Exam Laboratory Reports Radiology Reports Other
Behavioral Health/Sub. Abuse (check all that may apply): Hospital Summary Assessments Discharge Summary Physician Orders Progress notes Medications Lab reports Other

FORMAT: CD (charges may apply) Email Address noted above, where permitted Paper copy (charges may apply) Other
DELIVERY METHOD: Reg.US Mail Pick-up Fax, where permitted Overnight/Express Mail Service, where permitted Secure email Other:

PATIENT'S RIGHTS - I understand that:
I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
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.
Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.
A fee may be charged for providing the protected health information.
I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ Print Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
 Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Spouse
 Parent Adult Child Affidavit Next of Kin Other: _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

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

Authorization given to patient / Date of release: _____ via Mail Fax Other _____ ID Verified DL/Other ID _____

CHS Employee Name & Title: _____ CHS Employee Signature: _____ Date: _____