AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of: (one patient per form)

Patient Name: _____	Date of Birth: _____
_____ Street Address	Telephone: _____
_____ City, State, Zip	Email Address: _____ *Patient authorization to use e-mail and texting for communications of clinical information.*

Release Information From:	**Release Information To:**
Blue Ridge Health (ALL LOCATIONS)	_____ (Name of facility, person, company) (Relationship)
2579 Chimney Rock Road, Hendersonville, NC 28792	_____ (Street Address or PO Box, City, State, Zip Code)
828-631-3973 Phone Number	828-696-2350 Fax Number
	_____ Phone Number Fax Number

Purpose of Release ***Must select an option to be valid***	**Information authorized for disclosure, *if included in my records:*** ***Must select option(s) to be valid***	
☐Continued Patient Care ☐Attorney/Legal ☐Insurance ☐Benefit ☐Personal Use or Eligibility ☐School ☐Other, please specify: _____ **Select if you want to add dates of service or all dates:** ☐ Dates of Service, please specify: _____ ☐All Dates of Service	☐**Complete health record** *(includes all information listed below)* ☐Consultation Reports ☐Medication List ☐Billing Records ☐Problem/Diagnosis List ☐Radiology & Diagnostic Imaging Results ☐Treatment Plan ☐Behavioral Health Treatment Notes ☐School Collaboration ☐Laboratory tests, please specify: _____	☐Visit/ Discharge Summary ☐Clinical Office Notes ☐Immunization Records ☐History & Physical ☐Medication History ☐Clinical Assessment ☐Psychological Testing ☐Other, please specify: _____
All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information and Reproductive Health. *Specify any information you exclude:* _____		

PATIENT'S RIGHTS – I understand that:

- I may refuse to sign this authorization.
- I may request a copy of this signed agreement at any time.
- My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.
- I may revoke this Authorization at any time:
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to a BRH/Meridian clinic location.
  - The revocation will not apply to information that has already been released in response to this authorization.
- My information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (CFR 42, Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, part 160 and 164, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law
- 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.
- For court involved youth, a range of demographic, clinical, and service delivery information will be shared with those community partners identified in the treatment contract through various formats including staff meetings and transfer of electronic data.
- A fee may be charged for providing protected health information. Please contact BRH/Meridian Medical Records at 828.476.8783.

Unless otherwise revoked, this authorization will expire on the following date, event, condition: _____ . If I fail to specify an expiration date or event or condition, this authorization will expire automatically 365 days from the date of signature.

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: _____

I have read and understand the information in the Authorization form.

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted diseases 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 the authorization regardless of who consented for treatment.

Signature:_____ **Print Name:**_____ **Date:** _____
(Patient, Parent/Guardian, or Authorized Representative including Minor)

BLUE RIDGE HEALTH