Southern Regional AHEC Area Health Education Center

Phone (910) 678-7244
Fax (910) 678-7297

Authorization to Release Personal Health Information

Patient Name: _____

Date of Birth: _____

Telephone Number: _____

Release Medical Records from:

☐Southern Regional AHEC
☐Other _____
(Name of Facility or Physician **RELEASING** information)

_____
Address City State Zip Code Phone Number

Receive Medical Records:

☐ Southern Regional AHEC
☐ Self
☐ Other: _____
(Name of Facility, Person or Physician **RECEIVING** information)

How would you like the records to be released?
☐ Mailed ☐ In person pick up ☐ Faxed

☐ Paper Copy ☐ Electronic copy (CD)

Information to be Released:
☐ Entire Record
☐ Lab reports
☐ X-ray reports/films
☐ Office visit notes
☐ Other:_____
(Please specify information to be released)

Purpose for Release:
☐ Transferring Providers ☐ Legal
☐ Insurance ☐ Personal
☐ Moving out of state ☐ Other:_____
(Please specify)

I understand that my SR-AHEC medical records may contain information from other facilities that may be sent out when requested. By signing this authorization to release personal health information you are granting Southern Regional Area Health Education Center permission to re-disclose records we have obtained from other facilities.

CONTINUED ON BACK

The Practice is required to respond to you within (30) days of your request to inform you whether it will agree to your request or to inform you if the Practice needs more time to respond to your request.

Pursuant to the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to request that SOUTHERN REGIONAL AREA HEALTH EDUCATION CENTER (the "Practice") provide you with access to your protected health information. The Practice is not obligated to agree with your request in certain instances, including if (i) access to the information raises safety concerns, (ii) access to the information is limited by state law or court order, (iii) the PHI consists of psychotherapy notes, (iv) the PHI was complied by the Practice or one of the Practice's Business Associates in anticipation of or for use in a legal proceeding, (v) the PHI was obtained from someone other than a covered health care provider under a promise of confidentiality and access would likely reveal the source of the information, or (iv) the PHI was created or obtained by a covered health care provider in the course of research and the individual consented to the denial of access when consenting to participate in the research.

CHECK ONE OF THE FOLLOWING BOXES:

☐ **I DO** ☐ **I DO NOT** authorize the release of parts of the record that relate to substance abuse, psychological/psychiatric conditions and/or communicable diseases including Acquired Immunodeficiency Syndrome (AIDS) or tests for infection with Human Immunodeficiency Virus (HIV), if present.

I understand that I may take back/cancel this authorization at any time, except to the extent that action based on the authorization has been taken. This authorization will expire automatically one year from the date signed. Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I fully understand this authorization and it is made voluntarily on my part.

_____ _____
Signature of Patient or Legal Representative Date

What is your Relationship to the Patient?
☐ Self ☐ Legal Representative ☐ Other _____

Do you have Medical Power of Attorney if needed for this patient or Custody Papers if you are not the Legal Parent?(Please provide us with a copy)
- ☐ YES
- ☐ NO

For Office Use Only
Info Released:

_____ _____
Date Initials

_____ _____
Signature of Witness Date

RECORDS MAY NOT BE IMMEDIATELY AVAILABLE

THERE MAY BE A CHARGE FOR COPIES

☐ RELEASED AT TIME OF REQUEST ☐ PICTURE ID CHECKED

FM 03-30-98 revised 4/18/2017