Columbus Regional Healthcare System
500 Jefferson Street, Whiteville, North Carolina 28472
PHONE: 910-642-1783 / FAX: 910-642-9302

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Columbus Regional HEALTHCARE SYSTEM

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name:_____ Date of Birth:_____

Street Address:_____ Last 4 numbers of SSN:_____

City, State, Zip:_____ Telephone: ( )_____

Email Address:_____

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

PURPOSE OF RELEASE (check reason): ❑ Request of individual/personal ❑ Continued patient care ❑ Insurance
❑ Legal purpose including discussions and 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):		**Office/Clinic (check all that may apply):**
❑ Hospital Summary	❑ Emergency Record	❑ Office/Clinic Summary
❑ Discharge Summary	❑ Cardiac Reports/EKG	❑ Office Visits
❑ History and Physical	❑ Other_____	❑ Physical Exam
❑ Consultation Results	_____	❑ Laboratory Reports
❑ Operative Reports	_____	❑ Radiology Reports
❑ Laboratory Reports	_____	❑ Other_____
❑ Radiology/X-Ray Reports	_____	_____
❑ Pathology Reports		
❑ Entire Record (not including psychotherapy notes)		❑ Entire Record (not including psychotherapy notes)

FORMAT:	**DELIVERY METHOD:**
❑ CD (charges may apply)	❑ Reg. US Mail ❑ Pick-up ❑ Fax, where permitted
❑ Email address noted above, where permitted	❑ Overnight/Express Mail Service, where permitted
❑ Paper copy (charges may apply)	❑ Secure Email
❑ Other_____	❑ 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 my 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.
- CRHS will not share or use my health information without my permission other than by ways listed in CRHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at crhealthcare.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_____

CRHS Employee Name & Title:_____ CRHS Employee Signature_____ Date_____