CARILION CLINIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I,_____, do hereby authorize and request RADFORD UNIVERSITY STUDENT HEALTH SERVICES
(Print Full Name) (Name of Health Care Entity)
to release an disclose protected health information of:_____
(Patient Name)

Patient/Requestor Address
Patient's
Address:_____ Date of Birth:_____
_____ RU Student ID#:_____
_____ Cell Phone#:_____

TO:
Name: _____
Address: _____
_____
Phone: _____ Fax: _____

Please specify the Protected Health Information to be released by marking the following:
Are you requesting psychotherapy notes? ☐YES, then you may only request psychotherapy notes on this authorization. You must submit a separate authorization for other items. ☐NO, then you may check as many items below as you need.

☐ Discharge Summary	☐ History & Physical	☐ Operative Path Report
☐ Complete Record – sent to HealthPort and copy fees may occur	☐ Radiology Reports	☐ Emergency/Outpatient EKG/EEG/ECHO/Stress
☐ Other (Specify)	☐ Lab Reports	☐ _____ Treatment Date(s) Requested

I **acknowledge**, and hereby consent to such, that the released information may obtain alcohol, drug abuse, psychiatric treatment, sexually transmitted disease treatment, HIV testing, HIV results or AIDS information. _____**(initial)**.
The **Purpose** of this disclosure is for:_____Medical Care, _____Changing PCP/Family Physician, _____Changing Specialists, _____ Insurance Processing, _____Legal, _____at the request of Individual, _____other (Specify).

I understand that:

- By signing this Authorization, I am giving the Health Care Entity permission to disclose confidential Health records.
- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.
- I may withdraw (revoke) this Authorization in writing. Withdrawal of this Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice of revocation by the custodian of the health records.
- **This Authorization will automatically expire one year after the day below OR on _____.**
- **A fee may apply to copies of PHI that I request, whether received by me or by another recipient I authorize. I may ask for a cost/estimation/invoice prior to the information being copied.**

SIGNATURE:_____ **DATE:**_____
(Signature of Patient or Legally Authorized Representative) (Specify Date)

_____ _____
(Relationship to Patient if patient did not sign/Description of Authority to Act) **(Address and Telephone Number of Legally Authorized Representative)**

_____ **DATE:**_____
(Signature of Witness)

HIM Employee Verified Identification of Requestor_____(initial)

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.