**Please print legibly and complete all sections of this form. Return completed and signed form to – Attention: Health Information Management Department; Randolph Health, 364 White Oak Street, Asheboro, NC 27203; telephone 336-629-8861.**

| Print Patient Name (Last, First, MI): | Date of Birth: | MR# (Internal): | Acct# (Internal): |
|---|---|---|---|
| | | | |
| **Patient Address:** | **City, State:** | **Zip:** | **Telephone #:** |
| | | | |

**I hereby authorize ☐ Randolph Health or ☐_____to release copies of records on the above patient to ☐me ☐other:**

**NAME or FACILITY**: _____

**ADDRESS**: _____

**PHONE #**: _____ **FAX #**:_____

| Date(s) of Treatment/Period of Health Care: | Date Copies Needed By: | Mail ☐ Pick-up ☐ (ID Required) COPIES RELEASED: Yes ☐ No ☐ |
|---|---|---|
| | | |

**FORMAT of RELEASE REQUEST**:

__Paper __Flash Drive or CD __Email

**INFORMATION TO BE RELEASED** (Check all that applies):

__Complete Health Record (excluding all images) __Complete Health Record (including all images)
__Emergency Dept. Report __History & Physical Exam __EKG Report(s) __Record Review Request
__Pathology Report(s) __Operative Report __X-Ray Report(s) __Discharge Summary
__Consultation Report(s) __Laboratory Test(s) __X-Ray Film(s)
__Abstract (includes MD dictations & diagnostics) __Photographs, videotapes, digital or other images
__Other_____

**SENSITIVE INFORMATION TO INCLUDE** (Check all that applies):

__Treatment for alcohol and/or drug abuse __AIDS or HIV
__Mental health care or services __Psychotherapy Notes

**PURPOSE of RELEASE REQUEST**:

__ Continuing Medical Care __ Personal Care __ Legal Purposes
__ Insurance __ Military __ Social Security/Disability
__ Other_____

**ACKNOWLEDGEMENTS:**

**FEES**: I understand that I may be charged a fee for the preparation of a summary or explanation of my protected health information. I also may be charged a fee for reproduction costs to obtain a copy of my protected health information or to obtain a copy of the summary or explanation of my protected health information. If I request to have the information mailed to me, I understand that I may be charged a fee for mailing costs. If I request an electronic copy of my protected health information, I understand that I may be charged a fee for the media (i.e., CD, flash drive) on which my copy is stored and provided to me and for the labor costs associated with making the copy. **Initials:_____**

**VOLUNTARY AUTHORIZATION**: I understand this authorization is voluntary and I may refuse to sign it, at which time the requested records may not be released by Randolph Health. . **Initials:_____**

**REVOCATION**: This authorization expires 180 days from the date of signature, or at any time that I, as the patient, guardian, or legally authorized representative make a specific written request to revoke the written authorization. I understand that if I revoke this authorization, that revocation will not have any effect on actions the Organization took before receiving the revocation. **Initials:_____**

**SECONDARY USES & DISCLOSURES**: I understand that the information used or disclosed may be subject to re-disclosure by the recipient or facility receiving the health information. At that point, Randolph Health is not liable for how that information is used. Rather, the information will fall under the privacy notices and practices of the receiving organization. **Initials:_____**

**CONDITION TO RECEIVE TREATMENT**: I understand that Randolph Health cannot make me sign this authorization as a condition to receive treatment except 1) when the Organization provides me with research-related treatment, or 2) when the Organization provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. **Initials:_____**

**Form MUST be completed before signing.**

**Signature of Patient/Representative:** _____ **Date:** _____

**Printed Name of Patient or Representative:** _____

**Describe Representative's authority to act on behalf of Patient:** _____

_____

**Signature of Witness:** _____ **Date:** _____

Randolph Health

16400002

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)