Patient Name:_____ Date of Birth:_____
Last First MI/Maiden
Address:_____ City:_____ State:_____ Zip:_____

Last 4 of Social Security Number:_____ Telephone Number:_____

I hereby consent to and authorize IHS to ☐ Release to or ☐ Receive information concerning the history, treatment, examination and / or hospitalization of the above-named patient from / to the following facility(s) or individual(s):

Name of Facility(s) Individual(s) Receiving / Releasing Information

Address

Phone Number:_____ Fax Number:_____

I understand that the specific type of information to be released includes:
Treatment / Procedure Date(s):_____

☐ Abstract* (see back page)	☐ Consultation Reports	☐ Discharge Summary	☐ Emergency Department Report
☐ Entire Record	☐ Face Sheet	☐ History and Physical	☐ HIV / AIDS
☐ Lab, X-ray, EKG/ECG Reports	☐ Medication Record	☐ Nursing Notes	☐ Operative / Procedure Reports
☐ Outpatient Report	☐ Pathology Report	☐ Physician Orders	☐ Progress Notes
☐ Psychiatric Reports	☐ Therapy Notes	☐ Treatment Plans	☐ X-ray Film / Images
☐ Physician Office Notes	☐ Other (Specify):_____		

Purpose for Disclosure:

☐ Continuity of Care	☐ Disability Determination	☐ Insurance	☐ Legal Investigation
☐ Personal	☐ Worker's Compensation	☐ Other (Specify):_____	

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; make or receive payment; or enrollment or eligibility for benefits. I understand that the information in my health record my include information relating to treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric / psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and / or tests for antibodies to Human Immunodeficiency Virus (HIV).

I hereby authorize disclosure of the health information for the above-named patient and understand that it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. This authorization is valid for 60 days from the date of signature below unless I specify an earlier or later expiration date in this space _____. I understand that I may revoke this authorization at any time by notifying Hospital Administration or the Medical Records Director in writing. However, the revocation will be valid only as to future uses and disclosures of my protected health information if IHS has taken action in reliance on this authorization. I understand that I will be charged a copy fee for copies not mailed directly to a health care provider. See Fee Schedule for charges* (on back).

Signature of Patient or Personal Representative:_____ Date:_____
State Relationship of Personal Representative to Patient (as applicable):_____
Print Name and Title of Person Releasing Information:_____
Print Name / Initials of Person Verifying Information:_____
Verification of Identity Method: ☐ Photo ID ☐ Legal Description
Distribution Method: ☐ Paper ☐ Mail ☐ CD ☐ FAX ☐ Email ☐ Other:_____
For email communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

Authorization To Release Medical Information

Iredell Health System

557 BROOKDALE DRIVE
STATESVILLE, NC 28677-1828
PHONE 704-873-5661

For "Continuity of Care" the receiving caregiver typically only wants to receive an "Abstract "of key information from the Medical Record. This same "Abstract" sent to caregivers also almost always meets the needs for individual use.

A Medical Record "Abstract" contains the following:

- ✓ Discharge Summary – this document is a summary of the care, treatment, services provided and progress toward established goals of an inpatient stay
- ✓ Emergency Record – this record documents the care, treatment and services provided for a visit to the emergency room
- ✓ History & Physical – this form details the present illness or care needs and notes any relevant past history
- ✓ Operative Report(s) – this report details the surgeon's findings, technical procedures used, specimens removed and postoperative diagnosis
- ✓ Consultation(s) Report(s) – this report documents the findings of a physician requested to examine a patient
- ✓ X-Ray Reports, Labs, or other testing

Copy Fee Schedule

These rates are set by the state of North Carolina. A copy of NC General Statute 90-411 is below.

A minimum fee of $10.00 per request will be charged

CD's fee of $25 flat rate (No limit on pages)

Cost per Page	For Pages
$0.75	1 - 25
0.50	26 - 100
0.25	101 and up

90-411. Record copy fee.

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be seventy-five cents ($0.75) per page for the first 25 pages, fifty cents ($0.50) per page for pages 26 through 100, and twenty-five cents ($0.25) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs. If requested by the patient or the patient's designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record. This section shall only apply with respect to liability claims for personal injury, and claims for social security disability, except that charges for medical records and reports related to claims under Article 1 of Chapter 97 of the General Statutes shall be governed by the fees established by the North Carolina Industrial Commission pursuant to G.S. 97-26.1. This section shall not apply to Department of Health and Human Services Disability Determination Services requests for copies of medical records made on behalf of an applicant for Social Security or Supplement Security Income disability. (1993, c. 529, s. 4.3; 1993 (Reg. Sess., 1994), c. 679, s. 5.5; 1995 (Reg. Sess., 1996), c. 742, s. 36; 1997443, ss. 11.3, 11A.118(b).)

Authorization To Release Medical Information

DO NOT CHART

MR106
Rev. 07/19 Patient Copy

Iredell Health System

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