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 may 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

MR106 Rev.10/19	Iredell Health System	