CONE HEALTH

REQUEST & AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Last 4 SSN: XXX-XX-|___|___|___|___| **Telephone #:** _____

Address: _____

1. I authorize Cone Health or _____ to disclose the following information to:

Name: _____ Telephone:_____Fax: _____

Address: _____ City:_____State:____ ZIP: _____

2. Purpose of Disclosure:

☐ Patient Request ☐ Legal

☐ Continuity of Care ☐ Other (specify)_____

3. Requesting records from the following Cone Health site(s):

☐ The Moses H. Cone Memorial Hospital
☐ Alamance Regional Medical Center
☐ Alamance Regional Cancer Center
☐ Annie Penn Hospital
☐ Annie Penn Cancer Center
☐ Other: _____
☐ Behavioral Health Hospital
☐ Cone Health Cancer Center
☐ MedCenter High Point
☐ Wesley Long Hospital
☐ Women's Hospital

4. Dates of Service Requested: From:_____/_____/_____ To: _____/_____/_____

5. Information to be disclosed:

☐ Dates of Service
☐ Discharge Summary
☐ History and Physical
☐ Consultation Reports
☐ Operative Note
☐ Progress Notes
☐ Laboratory Results
☐ X-ray Reports_____
☐ ED Visit _____
☐ Other (specify) _____

Behavioral Health Specific:
☐ Psychosocial History
☐ Psychiatric Admission Assessment
☐ Therapy Notes
☐ Two-Way Communication
☐ After-Visit Summary (AVS)
☐ Suicide Risk Assessment at Discharge
☐ Letter (specify type) _____
☐ Other (specify type) _____

PATIENT RIGHTS AND SIGNATURE

1. I hereby authorize the use or disclosure of my individually identifiable health information as described above. This includes information pertinent to mental health, drug/alcohol abuse, and HIV/AIDS diagnosis.
2. Substance Abuse Records: I understand that my alcohol and/or drug treatment records are protected by the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
3. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization except for the purpose of treatment, payment, healthcare operations, and as required by law. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations
4. I understand this authorization will expire 90 days from the date signed unless a date is otherwise stated:_____
5. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Cone Health. I understand the revocation will not apply to information that has already been released in response to this authorization.
6. I understand that Cone Health cannot make me sign this authorization as a condition to receive treatment from Cone Health except: (i) when Cone Health provides me with research-related treatment; or (ii) when Cone Health provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
7. I understand that, if I request my records to be e-mailed or faxed, this is not considered secure and my health information could be viewed by someone other than me.
8. I understand there may be a charge associated with the Release of Information services rendered.

_____ _____
Patient signature Date/time

_____ _____
Signature of: ☐ Parent ☐ Guardian ☐ Authorized Representative *(attach copy of legal documents)* Date/time

OFFICE USE ONLY

_____ _____ _____
Driver's License # HIM Staff Signature Date

SHROI

54564 (07/14)