Erlanger Western Carolina Hospital
Authorization for Release of Medical Information

Patient/Resident Information: I give permission to release the health information of: **(one patient/resident per form)**

Patient/Resident Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip _____ Telephone: ( ) _____

Email Address: _____

Release Information From:	**Release Information To:** _____**myself**
_____	_____
(List Applicable Facility (s) and/or Practice)	(Name of facility, person. Company) (Relationship)
_____	_____
	(Street Address or PO Box, City, State, Zip Code)
_____	_____
(phone number) (fax number)	(phone number) (fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:
Treatment Dates: From: _____ **To:** _____

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic tests results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary
☐ History & Physical
☐ Consultation Reports
☐ Operative Reports
☐ Laboratory Reports
☐ Radiology/X-ray Reports
☐ Pathology Reports
☐ Emergency Room Record
☐ EKG
☐ Stress Test
☐ Other _____
☐ Entire Record (not including psychotherapy notes)

Office/Clinic/Other (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other _____
☐ Entire Record (not including psychotherapy notes)

FORMAT: (check all that may apply)
☐ CD (charges may apply)
☐ Secure - Email (E-Mail Address noted above)
☐ Paper copy (charges may apply)
☐ Other _____

DELIVERY METHOD:
☐ Reg. US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, charges may apply
☐ Other _____

PATIENT/RESIDENT RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2, genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **EWCH will not share or use my health information without my permission other than by ways listed in EWCH's Notice Of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.murphymedical.org.**
- **A fee may be charged for providing the protected health information.**
- **If I am requesting email transmission of my health information, I have read, understood and agree to the "GUIDELINES FOR E-MAIL WITH PATIENTS" document.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:** _____

Note: if the patient/resident lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient. Written proof may be requested.
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: if minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

EWCH Use Only _____

Authorization given to patient/Date of release: _____ via ☐ Mail ☐ Fax ☐ Other _____ ☐ ID Verified ☐ DL/Other ID _____
EWCH Employee Name & Title: _____ EWCH Employee Signature: _____ Date: _____ rev 8/19