Campbell County Health

OFFICE USE ONLY

Acct/MRN

Initials

Pages

Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete all sections entirely. If this authorization is not complete, it may be returned and resultin delay in processing. **Photo ID required at the time of request.**

Patient name:	**Date of Birth:**	**Telephone #:**

Patient Address: _____
Street City State Zip Code

Entity health information requested from: (Check all that apply)

☐ CCH Hospital ☐ CCMG Clinic/Provider: _____

☐ CCH Rehab services ☐ Other Healthcare Provider: _____

Dates of service to release: (from): _____ (to): _____

Specific reports to be disclosed: (Check all that apply)

☐ Abstract of record (Discharge Summary, H&P, Operative Records, Consults, Test Results….) ☐ Office Visit

☐ Emergency department record ☐ History & Physical ☐ Operative record ☐ Discharge Summary

☐ Immunization record ☐ Test results (Lab, Pathology, Radiology, and Cardiac) ☐ Itemized Bills

☐ Therapy Notes ☐ Other (Images, Photos): _____

☐ Entire record (standard two years of information, unless otherwise specified, fees may apply): _____

I authorize disclosure of the above listed information to the following individual or organization:

☐ Self or Name: _____

If mailing records, requested format: Paper or Electronic (PDF/CD) **PDF/CD default if not specified**

Information to be disclosed via: (Check one)

☐ Mail to Address: _____
Street City State Zip Code

☐ Fax to number: _____ (page limitation may apply)

☐ Secure email: _____ (I acknowledge the risks associated with information sent via email that is not secure and CCH is not liable for disclosures misdirected or intercepted in transmission).

Purpose for disclosure: _____
(Continuation of care, Insurance, Legal, please specify) – For Personal use if not otherwise stated

PATIENT'S RIGHTS:

- I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, sexually transmitted diseases and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy notes or Substance Abuse Disorder notes.
- This authorization will expire one year from completion date.
- I understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the right to the insurers to contest a claim under policy
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. Research participation requires a separate authorization by the patient. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are stated in the United States Code of Federal Regulations at section 164.524. I understand
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Release of Information department the request was submitted to.
- I understand if I am requesting my information while I am In House/Admitted or receiving on-going services, my record may not be complete, and I will need to request after services are completed and finalized. Records provided will be for treatment on the date of signature and/or prior to signature date.
- There may be a charge for copies of records.

_____ _____
Signature of Patient/Patient's Legal Representative Date

Relationship to patient: _____

Supporting documentation of authority must be provided (Guardianship, Executor of Estate, Power of Attorney)