Patient Information: I give permission to release the health information of: (One Patient Per Form)

Patient Name: ______________________ Date of Birth: ______________________

Street Address: ______________________ Last 4 numbers of SSN: ______________________

City, State, Zip: ______________________ Telephone: ( ) ______________________

Email address: ______________________

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for E-mail with Patients, posted on carolinashealthcare.org.

Release Information From:

Behavioral Health Charlotte

(List applicable Facility(s) and/or Practice(s)

501 Billingsley Rd Charlotte, NC 28211

704-358-2830 704-358-2969

(Phone number) (Fax number)

Release Information To:

____

(Name of facility, person, company)

____

(Street Address or PO Box, City, State, Zip Code)

____

(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** ______________________

Facility Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.

Office/Clinical Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Facility (check all that may apply):

☐ Facility Summary
☐ Discharge Summary ☐ Emergency Record
☐ History and Physical ☐ Cardiac Reports/EKG
☐ Consultation reports ☐ Other ____________
☐ Operative Reports ____________
☐ Laboratory reports ____________
☐ Radiology/X-Ray Reports ____________
☐ Pathology reports ____________

☐ Entire record (Not including psychotherapy notes)
☐ Itemized Bill

Office/Clinic/Home Care (check all that may apply):

☐ Office/Clinical Summary
☐ Office/Home Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other ____________

☐ Entire Record (Not including psychotherapy notes)
☐ Itemized Bill

Behavioral Health/Sub. Use (check all that may apply):

☐ Facility Summary
☐ Clinical/Discharge Summary
☐ Assessments
☐ Physician Orders
☐ Progress/Therapy Notes
☐ Medications
☐ Lab reports
☐ Other ____________

☐ Entire Record (Not including psychotherapy notes)
☐ Itemized Bill

FORMAT:

☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other ____________

DELIVERY METHOD:

☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: ____________

PATIENT'S 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.
- Atrium Health will not share or use my health information without my permission other than by ways listed in Atrium Health's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.
- A fee may be charged for providing the protected health information.

This permission expires one year after the date of my signature unless another date or event is written here: ____________

Signature: ____________ Print Name: ____________ Date: ____________

Note: If the patient 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: ____________

Authorization given to patient / Date of release: ____________ via ☐Mail ☐Fax ☐Other ____________ ☐ID Verified ☐DL/Other ID ____________

Employee Name: ____________ Date: ____________

Patient Information or Sticker

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name:
DOB:
Medical Record #: Account #:

Patient Information: I give permission to release the Psychotherapy Notes of: **(One patient per form)**

Patient Name: ______________________ Date of Birth: ______________________

Street Address: ______________________ MR# or last 4 numbers of ______________________

City, State, Zip: ______________________ Telephone: (   ) ______________________

Email address: ______________________

Release Information From:

Behavioral Health Charlotte

(List applicable Facility(s) and/or Practice(s)

501 Billingsley Rd., Charlotte, NC 28211

(Phone number)

Release Information To:

(Name of facility, person, company) (Relationship)

(City, State, Zip Code)

(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 the dates of therapy sessions for Psychotherapy Notes to be released:

Dates of therapy sessions:

From: ______________________ **To** ______________________

FORMAT: (Check all that may apply)

☐ CD (charges may apply)
☐ Paper copy (charges may apply)
☐ Other______________________

DELIVERY METHOD:

☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email, where permitted
☐ Other: ______________________

PATIENT'S 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 the facility or practice.**
- **This is a full release which may include information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, 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.**
- **Atrium Health will not share or use my health information without my permission other than by ways listed in Atrium Health's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org**
- **A fee may be charged for providing the protected health information.**
- **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 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:** ______________________

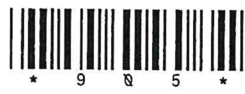
Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless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

Signature of Minor: ______________________ **Print Name:** ______________________ **Date:** __________

Authorization given to patient / Date of release: ______________ via ☐Mail ☐Fax ☐Other__________ ☐ ID Verified ☐ DL/Other ID______

Employee Name & Title: ______________________ **Employee Signature:** ______________________ **Date** __________

Patient Information or Sticker



AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Name:

DOB:

Medical Record #: