r

9331 33 9
33 9 11 33 9

____
Provider Name

○ Caswell Family Medical Center
P: (336) 694-9331
F: (336) 694-7511

or

○ James Austin Health Center
P: (336) 864-2795
F: (336) 864-2895

ACCESS OR AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company, health care provider, or other covered entity, the released information may no longer be protected by federal privacy regulations.

Patient Name: ____

Date of Birth: ______/_______/_________

Compassion Health Care, Inc. is authorized to ___ relase or ___ request the health information from:

Name: ____

Address: ____

City: ____________________ State: ______ Zip Code: __________

Telephone: (_____) ______-________ Fax: (_____) ______-________

Type of information to be released or disclosed:

- ○ Last 3 office notes
- ○ Latest labs
- ○ X-rays (except portable chest x-rays)
- ○ Specialist notes/reports for previous 2 years
- ○ Discharge summary
- ○ Other: ______________________________

Purpose of disclosure: ___ Medical Review ___ Legal Review ___ Insurance Review ___ Personal Use ___ Transition to Care

I understand that the health care provider requesting this authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information described herein. I understand that my health care and the payment for my health care will not be affected if I do not sign this form except to the extent that a release of medical information is required by a third party payor for services provided to me. I understand that the information release may include information relating communicable diseases such as HIV or AIDS, substance abuse or mental health treatment. I specifically authorize the release of such information as provided herein. I understand that I have the right to revoke this authorization at any time by notifying the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that with certain exceptions as provided by federal and state law, I may inspect or obtain a copy of the information to be used or disclosed. I further understand that if I ask for it, I have a right to a copy of this form after I sign it. I understand that this authorization will expire one year after the date I sign this form.

I agree that an electronic copy of this form shall have the same validity as the original.

Patient Name: ___________________________ Signature: ______________________________ Date: _____/_____/_______
(Patient/Authorized Representative)

If authorized Representative, please indicate relationship: Spouse _____ Parent _____ Other _____

*Please note, if information relating to the treatment of drug or alcohol abuse, communicable diseases, or treatment for mental health is being released for a patient under the age of 18, the patient must also sign this authorization if the patient is the person who consented to the treatment provided.

____
(Signature of Minor Patient)