

ALLEGHANY HEALTH

an affiliate of



PATIENT IDENTIFICATION

NAME: _____ DATE of BIRTH: _____
ADDRESS: _____ ZIP: _____ PHONE: _____

AUTHORIZATION TO:

Release Patient Information To: _____
Address: _____
Released From: Alleghany Health, LLC
Address: 233 Doctors St. Sparta, NC 28675

PATIENT INFORMATION TO BE RELEASED: (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> ER | <input type="checkbox"/> H&P | *Sensitive Information |
| <input type="checkbox"/> Consultation Notes | <input type="checkbox"/> Operative Report | ___ <input type="checkbox"/> *Mental Health |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Discharge Summary | ___ <input type="checkbox"/> *Alcohol Abuse/Treatment |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Progress Note(s) | ___ <input type="checkbox"/> *Drug Abuse/Treatment |
| <input type="checkbox"/> Images | <input type="checkbox"/> Complete Medical Record | ___ <input type="checkbox"/> *HIV Diagnosis/Treatment |
| | | ___ <input type="checkbox"/> *Other _____ |

DATES OF SERVICE TO BE RELEASED: From: _____ To: _____

INFORMATION TO BE: Picked Up Faxed (see fax/email release below)
 Mailed Emailed (see fax/email release below)

Fax/Email Release Notice I am aware that the above requested information is to be released via fax machine/email. I am also aware of the risks associated with faxing/emailing protected health information, and *sensitive information, including but not limited to: erroneous transmission, lack of confidentiality safeguards at the site of the receiving party and incomplete transmission information.

PURPOSE for which this information is being released: (check one)

- Continued Medical Care Legal Other _____
 Insurance Personal

I UNDERSTAND THAT:

The information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure and may no longer be protected by federal and state confidentiality laws. I may revoke this information at any time in writing, provided the information has not already been disclosed in reliance on this authorization.

I have read this entire form or have had it read to me. I understand the content. I hereby authorize the release of my patient information stated above and release Alleghany Health Hospital from any legal responsibility or liability relating to the release of information. This authorization is considered valid for a period of one year from the date of signature or until (date) _____.

Patient/Parent/Legal Agent Signature Relationship Date

Witness Signature Relationship Date