ALLEGHANY HEALTH

an affiliate of

Wake Forest Baptist Health | Hugh Chatham Memorial Hospital

PATIENT IDENTIFICATION

NAME: _____DATE of BIRTH: _____

ADDRESS: _____ZIP: _____ PHONE: _____

AUTHORIZATION TO:

Release Patient Information To: _____

Address: _____

Released From: _____Alleghany Family Medicine_____

Address: _____214 Doctors St. Sparta, NC 28675_____

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

☐ ER	☐ H&P	*Sensitive Information
☐ Consultation Notes	☐ Operative Report	____ ☐ *Mental Health
☐ X-Ray	☐ Discharge Summary	____ ☐ *Alcohol Abuse/Treatment
☐ Lab	☐ Progress Note(s)	____ ☐ *Drug Abuse/Treatment
☐ Images	☐ Complete Medical Record	____ ☐ *HIV Diagnosis/Treatment
		____ ☐ *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, proved 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

Rev: 26June2018