ALLEGHANY HEALTH

an affiliate of Atrium Health Wake Forest Baptist | Hugh Chatham Health

PATIENT IDENTIFICATION

Name: _____ Date of Birth: _____

Address: _____ Zip: _____

Phone: _____

AUTHORIZATION TO:

Release Patient Information To: **ALLEGHANY HEALTH, LLC**

Address: **233 DOCTOR ST. SPARTA 28675 P: 336-372-3293 F: 336-372-6032**

Released From: _____

Address: _____

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 IS 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