

Authorization to Release Medical Records or Protected Health Information

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Medical Record #: _____
Date of Visit(s) Needed: _____ Account (fin)#: _____

I hereby authorize: () Pardee Hospital or () Other facility: _____
To share information with _____
Address or Fax Number _____

The medical information or part of the medical record that will be shared includes:
() Abstract () Whole Chart () ER visit () Dictation () Labs () Radiology () Medications () EKG
() Procedure note & pathology () Other _____

The purpose of this release is: () Continued care () Legal () Insurance () Disability () Personal
() Other _____

I understand that:

- I am authorizing the health care provider listed to provide copies of my medical record even though it may contain private information about: rape, abuse (sexual, physical, elder, spousal, etc), genetics, abortion, sexual disease, illnesses like hepatitis or AIDS, ARC (AIDS-related complex), HIV and AIDS testing, substance abuse, and/or mental illness.
- The health care provider listed above has no control over how my medical records will be used by the people who receive them. These people may copy and provide my medical records to other people who do not have to obey state or federal laws protecting the privacy of medical records.
- My decision to sign this authorization will not affect the treatment provided to me by the health care provider, the cost of that treatment or my benefits.
- I may ask for and get a copy of this authorization.
- A readable photocopy/fax of this authorization shall have the same force and effect as the original.
- This authorization will expire in 90 days (or unless a date or event is written).
- I can cancel this authorization at any time by writing to the health care provider’s Privacy Officer or Health Information Management Department at the address listed below. I understand that canceling will not affect my insurance company’s right, if any, to contest a claim under my policy. I also understand that my cancellation may not apply to information already sent out.
- I release the health care provider, its employees, officers and physicians from any legal responsibility or liability for this disclosure to the extent indicated and authorized.

() THIS AUTHORIZATION WILL BE USED TO FAX EMERGENCY INFORMATION.

Patient or Representative Signature Date: _____

Patient or Representative Identification Contact Phone Number
() Parent () Legal Guardian () Executor of Estate () Next of Kin () Healthcare Power of Attorney
() Other _____

Witness Date: _____



Mailing Address: Pardee Hospital • 800 North Justice Street • Hendersonville, NC 28791
General Phone (828) 696-1000 • Medical Records (828) 696-1096 • Fax (828) 696-1097