

HGCS SUMMER CAMP 2017

Patient Information: I give permission to release the health information of:

(One Patient Per Form)

Patient Name: _____	Date of Birth: _____
Street Address: _____	Last 4 numbers of SSN: _____
City, State, Zip: _____	Telephone: () _____
Email address: _____	

Release Information From: Carolinas Healthcare System _____ (List applicable Facility(s) and/or Practice(s)) _____ _____ (Phone number) (Fax number)	Release Information To: <u>Hickory Grove Christian School</u> (Name of facility, person, company) (Relationship) _____ <u>7200 E. WT Harris Blvd. Charlotte, NC 28215</u> (Street Address or PO Box, City, State, Zip Code) _____ <u>704-531-4198</u> (Phone number) (Fax number)
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PURPOSE OF RELEASE (check reason): Request of individual/personal Continued patient care Insurance
 Legal purpose including discussions & proceedings Other Sports Medicine including oral & written communication

Fill in dates of treatment for records to be released:

Treatment dates: From June 1, 2017 To July 31, 2017

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.

Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply): <input type="checkbox"/> Hospital Summary <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Record <input type="checkbox"/> History and Physical <input type="checkbox"/> Cardiac Reports/EKG <input type="checkbox"/> Consultation reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Operative Reports _____ <input type="checkbox"/> Laboratory reports _____ <input type="checkbox"/> Radiology/X-Ray Reports _____ <input type="checkbox"/> Pathology reports _____ <input type="checkbox"/> Entire record (Not including psychotherapy notes)	Office/Clinic (check all that may apply): <input type="checkbox"/> Office/Clinic Summary <input type="checkbox"/> Office Visits <input checked="" type="checkbox"/> Physical Exam <input checked="" type="checkbox"/> Laboratory Reports <input checked="" type="checkbox"/> Radiology Reports <input checked="" type="checkbox"/> Other <u>Research Participation</u> _____ <input type="checkbox"/> Entire Record (Not including psychotherapy notes)	Behavioral Health/Sub. Abuse (check all that may apply): <input type="checkbox"/> Hospital Summary <input type="checkbox"/> Assessments <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Physician Orders <input type="checkbox"/> Progress notes <input type="checkbox"/> Medications <input type="checkbox"/> Lab reports <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire Record (Not including psychotherapy notes)
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FORMAT: <input type="checkbox"/> CD (charges may apply) <input type="checkbox"/> Email Address noted above, where permitted <input type="checkbox"/> Paper copy (charges may apply) <input type="checkbox"/> Other _____	DELIVERY METHOD: <input type="checkbox"/> Reg.US Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax, where permitted <input type="checkbox"/> Overnight/Express Mail Service, where permitted <input type="checkbox"/> Secure email <input type="checkbox"/> Other: _____
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PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Spouse
 Parent Adult Child Affidavit Next of Kin Other: _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release: _____ via Mail Fax Other _____ ID Verified DL/Other ID _____
 CHS Employee Name & Title: _____ CHS Employee Signature: _____ Date: _____

905



Name: _____
 DOB: _____
 Medical Record #: _____
 Account #: _____

Patient Information or Sticker