Tri-Area Community Health
www.triareahealth.org

**Laurel Fork**, 276-398-2292
**Ferrum,** 540-365-4469
**Floyd**, 540-745-9290
**Grayson Highlands,** 276-579-1235
**Stuart**, 276-694-4466

# *Authorization for Release of Protected Health Information*

Patient Name (Last, First, Middle Initial) _____ Maiden or Other Name _____

Date of Birth _____ SSN# _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip _____ Email _____

☐ **I hereby authorize** _____ (print name of provider) **to release information from my file as indicated below to:**

**Tri-Area Community Health**
**Send all correspondence to:**
P. O. Box 9
Laurel Fork, VA 24352
276-398-3331 FAX

☐ **I hereby authorize Tri-Area Community Health to release information from my medical record as indicated below to:**

_____

## INFORMATION TO BE RELEASED:

| | DATES |
|---|---|
| ❑ History and Physical Exam | _____ |
| ❑ Progress Notes | _____ |
| ❑ Lab Reports | _____ |
| ❑ X-ray Reports | _____ |
| ❑ Other _____ | _____ |

I specifically authorize the release of information relating to:

- ❑ Substance Abuse (including alcohol/drug abuse)
- ❑ Mental Health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

_____ _____
Signature of Patient or Legal Guardian Date

**Purpose of release:**

- ❑ Continuation/Coordination of Care, follow-up treatment or ongoing care
- ❑ Other _____

## AUTHORIZATION:

- I understand this authorization will expire in 1 year after I have signed this form.
- I understand I may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified except to the extent action has already been taken.
- I understand information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations
- I understand that while there is usually no charge for medical records if copies are sent for ongoing care or follow up treatment, **some facilities charge for transfer of records. The patient is responsible for any charges related to the transfer of records.**

_____ _____
Signature of Patient/Legal Guardian Date