Tri-Area Community Health
www.triareahealth.org

Fax Number for all locations: (276) 398-3331

Cana Phone (276)755-2203
Ferrum Phone (540) 365-4469
Floyd Phone (540) 745-9290
Fries Phone (888) 908-4788
Grayson Highlands Phone (276) 579-1235
Laurel Fork Phone (276) 398-2292
School Sites

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 _____

Is the patient a minor or have a legal guardian? ❑ Yes ❑ No If Yes, Name of legal guardian: _____

If Yes, Name of Person completing this form: _____ Relationship _____

☐ **I hereby authorize** (Provider Name)_____
Practice Name:_____
Address: _____Phone/Fax Number: _____
to release information from my file as indicated below to (send all correspondence to:
Tri-Area Community Health, PO Box 9,Laurel Fork, VA 24352 Fax: 276-398-3331

☐ **I hereby authorize Tri-Area Community Health to release information from my medical record as indicated below to:**
Name: _____
Address: _____Phone/Fax Number:_____

INFORMATION TO BE RELEASED:

	DATES
❑ **ALL**	_____
❑ Billing Summaries	_____
❑ History and Physical Exam	_____
❑ Immunizations	_____
❑ Lab Reports	_____
❑ Progress Notes	_____
❑ X-ray Reports	_____
❑ Other _____	

I specifically authorize the release of information relating to:
Dates: _____
❑ **Substance Abuse** (including alcohol/drug abuse)
❑ **Mental Health/Behavioral Health Therapy 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
❑ Changing Providers _____
❑ Disability Determination _____
❑ Other (please specify)_____
❑ Legal
❑ Second Opinion
❑ Workers Compensation

AUTHORIZATION:

- I understand this authorization will expire 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 that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I further understand that TACH cannot condition the provision of treatment to me on my signing of this authorization.
- A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless the recipient is a provider who makes a disclosure permitted by law. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA policy rule.

_____ _____
Signature of Patient/Legal Guardian Date