

Authorization to Disclose Protected Health or Billing Information

For Use by SCR Acute Facilities and Clinics

(One patient per form)

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

Patient Name: _____
 Street Address: _____
 City, State, Zip: _____
 Email address: _____

Date of birth: _____
 Last 4 numbers of SSN: _____
 Telephone: () _____

Although Novant Health will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release Information From: _____ (list applicable Facility(s) and/or Practice(s))	Release Information To: _____ (Name of facility, person, company) (Relationship) _____ (Street address or PO Box, City, State, Zip code) _____ (Phone number) (Fax number)
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Purpose of Release (check reason): Request of individual / personal Insurance Disability Workers Compensation
 Legal purpose including discussions & proceedings Other: _____

Must fill in dates of treatment for records to be released: Treatment dates FROM: _____ TO: _____

CHOOSE ONE: I would like the parts of my record selected below to be released:

Option 1: <input type="checkbox"/> Treatment Summary (Abstract) *includes all physician notes, orders and results from the location and dates of service indicated above.	OR Option 2: Partial Record (choose specific items below if you do not need the entire chart or abstract) Physician Notes: <input type="checkbox"/> All <input type="checkbox"/> History & Physical <input type="checkbox"/> Progress Notes <input type="checkbox"/> Office Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative/Procedure Notes <input type="checkbox"/> ER Notes <input type="checkbox"/> Consultation Notes <input type="checkbox"/> Immunization Summary *Includes available immunizations documented in the medical records chart only. Not an official state copy Orders and Results: <input type="checkbox"/> All <input type="checkbox"/> Cardiac/EKG <input type="checkbox"/> Laboratory <input type="checkbox"/> Diagnostic Testing <input type="checkbox"/> Radiology/X-ray <input type="checkbox"/> Pathology <input type="checkbox"/> Medications <input type="checkbox"/> Other: _____	OR Option 3: <input type="checkbox"/> Entire Record (not including psychotherapy notes)
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Additional Options: <input type="checkbox"/> Billing Information <input type="checkbox"/> Estimates <input type="checkbox"/> Certification of Records <input type="checkbox"/> Certification and Affidavit of Records <input type="checkbox"/> Radiology Images (CD) *CDs containing radiology images are separate from a medical records CD and charges apply.	Send Completed Form To: Mailing Address: 25 Hospital Centre Blvd. Hilton Head Island, SC 29926 Email: ROI@NovantHealthSC.com Phone (Toll Free) 1-800-367-1500 Fax 843-410-2724
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Delivery Method: A fee may be charged for providing the protected health information. Please visit our website for a list of fees.
www.novanthealth.org/medicalrecords

MyChart (only available to patients) NH LINK (only available to 3rd party) Fax E-mail Paper Copy via USPS CD/DVD
 Other: _____
 Patient Waiting (onsite pick up) *Novant Health clinics and hospitals may only be able to release a limited amount of records onsite. All other requests are processed by the Novant Health Enterprise Release of Information department.

- 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, unless limited by the above selections.
 - 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, enrollment in health plan, or eligibility for benefits.
 - I have a right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print name:** _____ **Date/Time:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

If you are not the patient or the parent of a minor patient, you **MUST** attach documentation of your authority to act on behalf of the patient.

(Note the relationship/authority below)
 Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Parent Next of Kin Other: _____

Signature of minor: _____ **Print name:** _____ **Date/Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
 Interpreter Accepted _____ Interpreter Refused _____
 (Name/Number of Person/Services Chosen/Used)