Authorization to Disclose Protected Health or Billing Information

For Use by SCR Acute Facilities and Clinics

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: _____

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:	**Release Information To:**
(list applicable Facility(s) and/or Practice(s))	(Name of facility, person, company) (Relationship)
	(Street address or PO Box, City, State, Zip code)
	(Phone number) (Fax number)

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:	**OR**	**Option 2:**	**OR**	**Option 3:**
☐ **Treatment Summary** (Abstract) *includes all physician notes, orders and results from the location and dates of service indicated above.		**Partial Record** (choose specific items below if you do not need the entire chart or abstract) **Physician Notes:** ☐ All ☐ History & Physical ☐ Progress Notes ☐ Office Notes ☐ Discharge Summary ☐ Operative/Procedure Notes ☐ ER Notes ☐ Consultation Notes ☐ Immunization Summary *Includes available immunizations documented in the medical records chart only. Not an official state copy **Orders and Results:** ☐ All ☐ Cardiac/EKG ☐ Laboratory ☐ Diagnostic Testing ☐ Radiology/X-ray ☐ Pathology ☐ Medications ☐ Other:		☐ **Entire Record** (not including psychotherapy notes)

Additional Options:	**Send Completed Form To:**
☐ Billing Information ☐ Estimates ☐ Certification of Records ☐ Certification and Affidavit of Records ☐ Radiology Images (CD) *CDs containing radiology images are separate from a medical records CD and charges apply.	**Mailing Address:** 25 Hospital Center Blvd. Hilton Head Island, SC 29926 **Email**: ROINovantHealthSC@datavant.com **Phone (Toll Free)** 855-215-4683 **Fax** 843-410-2724

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)