Watauga Medical Center Inc.| 336 Deerfield Rd., Boone, NC 28607| P: (828) 262-9581| F: (828) 265-5014
Charles A. Cannon Jr., Memorial Hospital Inc.| 434 Hospital Dr., Linville, NC 28646| P: (828)737-7547| F: (828)737-7531
The Foley Center at Chestnut Ridge| 621 Chestnut Ridge Pkwy., Blowing Rock, NC 28605| P: (828)386-3268| F: (828) 386-3269

APPALACHIAN REGIONAL HEALTHCARE SYSTEM

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

#1

Patient Name (First, Middle, Last)	Date of Birth	Telephone #	
Address	City	State	Zip

#2

I authorize: ☐ Wataugа Medical Center INC. ☐ Charles A. Cannon Jr., Memorial Hospital INC. ☐ The Foley Center at Chestnut Ridge

…To release my Protected Health Information "PHI" as described below to: ☐ **Self** (or indicate receiver below)

#3

Receiver	Telephone #	Fax #	
Address	City	State	Zip

#4

For the purpose of: ☐ Personal Copies ☐ Healthcare ☐ Legal ☐ Other: ____

INFORMATION TO BE RELEASED TO RECEIVER

DATE(S) OF TREATMENT: ____

#5

☐ Basic Set (Lab/ Rad results and Provider Notes) ☐ Complete Record (Basic & Clinical Documentation, Other)
☐ Discharge Summary ☐ History and Physical ☐ Emergency Reports ☐ Operative Notes
☐ Laboratory Reports ☐ Radiology Reports ☐ Imaging CD's ☐ EKG/ Cardiac Studies
☐ Physical Therapy ☐ Mental/Behavioral Health Services ☐ Other:____

#6

REQUESTED FORMAT	DELIVERY METHOD
☐ Paper ☐ CD	☐ Pick-Up ☐ US Mail ☐ Fax (to healthcare providers only) ☐ Email
☐ Flash Drive ☐ Email	**Email Address:**____

My signature below indicates that I understand the following:

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- There is no guarantee of confidentiality when communicating by email. If you ask us to email you protected health information, you understand and agree that neither ARHS, or its affiliates, are responsible for the security and confidentiality of email communications (including attachments) once it leaves our control, including what you do with the information, what happens to the information both in transit and upon arrival, and who else sees the information. By asking us to email you protected health information, you understand and agree to accept these risks.
- I may revoke this authorization at any time by notifying Appalachian Regional Healthcare System and affiliates "ARHS" in writing
- Revoking this authorization will not have any effect on any actions ARHS took before it received the revocation.
- A revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to submit the claim.
- If my record contains sensitive information relating to communicable diseases, HIV status, alcohol/drug abuse, psychological/psychiatric conditions, or genetic testing, this disclosure will include that information.
- ARHS has the right to deny the release of Behavioral Health Records at the discretion of the attending physician.
- I have the right to request a restriction on uses and disclosures of my health information. Except where ARHS is required by law to disclose the information
- I have the right to ask ARHS not to use or disclose certain health information maintained over the course of my care. I understand that to request a restriction, I may complete a Request for Restriction of Protected Health Information form.
- This authorization expires at the time the disclosure of protected health information is completed.
- Fees/charges will comply with all laws and regulations applicable to release of information.

The Healthcare provider listed above is hereby released from all legal liability that may arise from the release of the information requested. I further understand that I may request a copy of this authorization. Please allow up to thirty (30) days to process your request.

#7

▶
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE / TIME

NAME OF LEGAL REPRESENTATIVE RELATIONSHIP OF LEGAL REPRESENTATIVE

▶
SIGNATURE OF WITNESS DATE / TIME

▶
SIGNATURE OF EMPLOYEE COMPLETING AUTHORIZATION (*OFFICE USE ONLY*) DATE / TIME

***Staff Use Only*:** Verified Photo ID _____________ (Initial Here)

# of pages released____________ MR#______________

APPALACHIAN REGIONAL
HEALTHCARE SYSTEM

Instructions for HIPAA Authorization for Use or Disclosure of Protected Health Information (PHI)

GUIDE TO MEDICAL RECORDS REQUEST

Watauga Medical Center Inc., Charles A. Cannon Jr., Memorial Hospital Inc.
and The Foley Center at Chestnut Ridge

#1 **PATIENT INFORMATION:** Enter the name, birthdate, telephone number, and address of the individual whose health information will be released.

#2 **FACILITY TO DISCLOSE:** Select the facility that you want your records released from. (You may select more than one facility).

#3 **INDIVIDUALS TO RECEIVE:** Check box for "Self" if you want this information released directly to you, or enter the name, address, telephone, and *fax number of the individual(s) you want to receive your information.
**Note: Medical records will only be faxed to a healthcare facility.*

#4 **PURPOSE OF REQUEST:** Personal copies are any copies not going directly to a healthcare provider, charges for personal copies comply with federal and state regulations/laws. Continuum of care (Healthcare) records are released directly to a healthcare provider at no charge.

#5 **INFORMATION TO BE RELEASED**
Specify dates of treatment and records to be released. If you are unsure of the dates, please list the month/year and type of services, (Example: "August 2016 ED Visit.")

#6 **FORMAT & DELIVERY METHOD**
Please indicate if you want your records as paper copies, or electronic format (Email, CD, Flash-Drive). Be aware that some facilities may not accept a CD or flash-drive to view your records due to computer safety, paper copies are best for sharing with healthcare providers. Please specify a delivery method (Picked up, mail, fax, or emailed.)

#7 **SIGNATURE(S):** Patient or patient's legal representative must sign authorization. Healthcare Power of Attorney or appointment of guardianship documentation MUST be provided if not on file with ARHS.

PHOTO ID: Copy of patient's photo ID must be provided with the request. A witness signature is required if patient's photo ID is not available.

FAILURE TO FOLLOW GUIDELINES MAY RESULT IN A DELAY IN PROCESSING YOUR REQUEST.

For Help or Questions

Watauga Medical Center: (828) 262-9581 option # 3

Charles A. Cannon Jr., Memorial Hospital: (828) 737-7547

The Foley Center at Chestnut Ridge: (828) 386-3268