



## Eastern Shore Rural Health System, Inc.

### Authorization for Release of Information / Obtaining Health Records

Information Requested for:							
Patient Name:	Last Name	First Name	Date of Birth (Mo./Day/Yr.):				
Former Name:			Medical Record #:				
Address:			City:	State:		Zip:	
Day Phone:			Email:				
I Hereby Authorize To Disclose my Protected Health Information To							
<b>Name</b>			<b>Name</b> Eastern Shore Rural Health				
<b>Address</b>			<b>Address</b> 9159 Franktown Rd				
<b>City, State &amp; Zip</b>			<b>City, State &amp; Zip</b> Franktown, VA 23354				
<b>Phone</b>			<b>Phone</b> 757-442-4819				
<b>Fax</b>			<b>Fax</b> 757-442-9505				
Information to be Released				Dates Requested (Year to Year): _____ to _____			
<input type="checkbox"/> Verbal Communication		<input type="checkbox"/> Exam Progress Reports _____		<input type="checkbox"/> Lab / X-Ray Reports _____			
<input type="checkbox"/> Discharge Summary _____		<input type="checkbox"/> History and Physical _____		<input type="checkbox"/> Medication Records _____			
<input type="checkbox"/> Emergency Records _____		<input type="checkbox"/> Immunization Records _____		<input type="checkbox"/> Other _____			
I specifically authorize the release of information relating to:							
<input type="checkbox"/> Substance Use / Substance Use Treatment (Including Alcohol / Drug Use) <input type="checkbox"/> Mental / Behavioral Health Treatment <input type="checkbox"/> HIV Related Information (e.g., AIDS-Related Testing)							
<ul style="list-style-type: none"> <li>I understand that my substance use disorder treatment records, if any, are protected under Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 &amp; 164, and cannot be disclosed without my written consent unless otherwise required for by the regulations, by other applicable law, or by an Order of a court.</li> </ul>							
Purpose of Disclosure: There is no charge for copies sent to facilities for on-going care.							
<input type="checkbox"/> Transfer of Care		<input type="checkbox"/> School / Academic					
<input type="checkbox"/> Consultation		<input type="checkbox"/> Legal (Please Specify): ** _____					
<input type="checkbox"/> Coordination of Care		<input type="checkbox"/> Personal Access (Specify): ** <input type="checkbox"/> Copy <input type="checkbox"/> Inspection <input type="checkbox"/> Summary					
<input type="checkbox"/> Disability		<input type="checkbox"/> Other (Please Specify): _____					
** <b>Charges may apply.</b> Prior to release charges will be discusses with requestor.							
Method of Delivery of Records: To be determined based on number of pages and electronic capabilities.							
Patient Understanding:							
<ul style="list-style-type: none"> <li>I certify that I am 18 years of age or older or am the legal representative (e.g., parent, legal guardian, legal custodian, conservator, guardian <i>ad litem</i>, attorney-in-fact under a power of attorney, or executor of decedent) of the service recipient, excepting in circumstances whereby I have medical consent to services as designated by State and / or Federal Law (i.e., Substance Use, Mental Health Treatment, Sexually Transmitted Disease Treatment).</li> <li>I understand that the records I authorize for release may include information about family planning services and communicable diseases. I also understand that by authorizing release of records, there may be limited information included about substance use and/or behavioral health diagnoses and treatment in the record.</li> <li>I understand that this authorization is valid for 12-months from the date of signature and that I may revoke this authorization by written notification signed by me, and that it will not affect any information released prior to written notification of revocation.</li> </ul>							
<b>Patient / Legal Representative Signature:</b>						<b>Date:</b>	
<b>Relationship to the Patient:</b>							
<b>Records Received By:</b>						<input type="checkbox"/> <b>ID Verified</b>	
						<b>Date:</b>	