Patient Name: _____ Date of Birth: _____ Phone: _____
Address: _____

I hereby authorize (select appropriate locations) to use or disclose my health information as described below.

❑ Mission Hospital ❑ Angel Medical Center ❑ Blue Ridge Regional Hospital ❑ CarePartners
❑ Highlands-Cashiers Hospital ❑ McDowell Hospital ❑ Transylvania Regional Hospital
❑ Physician Practice _____ ❑ Other _____

❑ Disclose the **requested information** (select below) from my medical records / the records of the patient listed above to:

_____
Name (facility, person, organization)

_____
Address City /State

_____
Phone/ Fax

❑ Access the **requested information** (select below)
- ❑ Inspect/view my PHI;
- ❑ Inspect/view a summary or explanation of my PHI;
- ❑ Obtain a copy of my PHI; or
- ❑ Obtain a copy of a summary or explanation of PHI

❑ Use my protected health care information for the following purposes: _____

Purpose for Disclosure: ❑ Legal ❑ Insurance ❑ Personal ❑ Healthcare ❑ Worker's Comp ❑ Other: _____

Hospitals
❑ Basic Set (Lab/Rad Results, Provider Notes, H&P, Op Note)
❑ Complete Set (Basic & Clinical Documentation, Other)
❑ ER Record ❑ Lab Results ❑ Pathology Report
❑ EKG/Cardiac Studies ❑ X-Ray reports
❑ Other: _____

Clinics / Office
❑ Lab results ❑ Billing info ❑ Entire Record
❑ Office Visits ❑ Physical Exams
❑ Other: _____

*release does Not include psychotherapy notes

Date(s) of Treatment: _____

Requested Format: ❑ Electronic Media ❑ Paper ❑ View only (appointment) ❑ Other: _____
Delivery Method: ❑ US Mail ❑ Pick-up ❑ Fax _____ ❑ Other _____

My signature below indicates that I understand the following:

- This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
- As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- My decision to sign this authorization will not have an affect on the treatment provided to me by the health care provider, the cost of that treatment, or my benefits.
- I may revoke this authorization at any time by notifying Mission Health's HIM Department in writing.
- Revoking this authorization will not effect any disclosures made prior to revoking this authorization.
- Unless revoked or an **expiration date** is indicated here _____, this authorization will expire in 90 days.
- After release my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permission.
- Mission Health will not use or share my health information without my permission, except as allowed or required by law.
- This form will not be used for marketing or research.
- A fee may be charged for providing the requested medical records.
- I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my health information as described in this form.

Signature: _____ Date: _____ Time: _____
Patient or Representative Signature
If Representative, Indicate Relationship to Patient.
❑ Parent ❑ Legal Guardian ❑ Executor of Estate ❑ Power of Attorney ❑ Other: _____
Proof of documentation of relationship may be required

Contact Information:
HIM Department
509 Biltmore Ave
Asheville, NC 28801 (828) 213-0636

DO NOT WRITE IN MARGIN

MHS-04640-115-0915

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MISSION HEALTH

Authorization for Access, Use, or Disclosure of Protected Health Information

DO NOT WRITE IN MARGIN