ASHE MEMORIAL HOSPITAL, INC

200 HOSPITAL AVENUE, JEFFERSON, N. C. 28640 (336) 846-7101

Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations			
Patient Name:	**Birth Date:**	**Medical Record Number:**	
Recipient's Name:	**Address :**		
	City:	**State:**	**Zip:**

This authorization will automatically expire one year from the date signed, or as specified below:
(Fill in the Date or the Event but not both)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ Admission form ☐ History & Physical ☐ Discharge summary ☐ Operative notes ☐ Physician orders ☐ Progress notes ☐ Medication sheets ☐ Consults		☐ Pathology reports ☐ EKGs ☐ Nursing documentation ☐ Transfer forms ☐ ED information ☐ Laboratory reports ☐ Imaging reports		☐ Labor/delivery summary ☐ OB nursing assessment ☐ Postpartum flow sheet ☐ Itemized bill: ☐ Billing claim: ☐ EMR: discharge instruction & medication list only ☐ EMR for selections above ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to Ashe Memorial Hospital, Inc, Medical Records Manager, 200 Hospital Ave, Jefferson, N. C. 28640, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/ Legal Representative:	**Date:**
Print Name of Patient/Patient's Representative:	**Relationship to Patient:**
Witness:	**Date:**
Information received by:	**Date:**
Witness:	**Date:**