INCOMING TO MAHEC

MAHEC Center for Psychiatry
Centralized Medical Records Department
125 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patient Name: _____ **Date of Birth:**_____

I authorize the use or disclosure of the above named individual's health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY:	**MAHEC Center for Psychiatry** **Centralized Medical Records Dept.**
ADDRESS:	**125 Hendersonville Road**
CITY/STATE: PHONE #: FAX #:	**Asheville, NC 28803**

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

- ❑ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- ❑ Only information related to *(specify)*: _____
- ❑ Only the period of events from: _____ to _____
- ❑ Entire medical record
- ❑ Exclusions
  - __ AIDS/HIV test results, diagnosis, treatment, and related information
  - __ Drug screen results and information about drug and alcohol use and treatments
  - __ Mental health notes
  - __ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. _____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

OUTGOING FROM MAHEC

MAHEC Center for Psychiatry
Centralized Medical Records Department
125 Hendersonville Road, Asheville, NC 28803
Business Office Phone: (828) 771-5489 Fax: (828) 407-2637

Patient Account#:_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ALL SECTIONS of this form MUST be complete before your request can be processed.
Don't forget to sign and date at bottom before submitting.

Patient Legal Name: _____DOB:_____

I authorize the use or disclosure of the above named individual's health information as described below. **If the request is for more than 50 pages, the documents will be mailed and not faxed. Please confirm mailing address below.**

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY **MAHEC Center for Psychiatry Centralized Medical Records Dept.**	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS **125 Hendersonville Road**	ADDRESS
CITY/STATE/ZIP **Asheville, NC 28803**	CITY/STATE PHONE #: FAX #:

The purpose or need for this disclosure is:

_____

I would like to receive my records via: ☐ Fax ☐ Mail ☐ In-Person (___ paper or ___ CD)

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

☐ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
☐ Only information related to *(specify)*: _____
☐ Only the period of events from: _____ to _____
☐ Entire medical record
☐ Exclusions __ AIDS/HIV test results, diagnosis, treatment, and related information
__ Drug screen results and information about drug and alcohol use and treatments
__ Mental health notes
__ Genetics testing

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