# Mountain Community Health Partnership

MedRecReq


BCHC
86 North Mitchell Ave
Bakersville, NC 28705
(828) 688-2104
(828) 688-1334 fax

CHC
116 Seven Mile Ridge Rd
Burnsville, NC 28714
(828) 675-4116
(828) 675-9312 fax

SPHC
36 Hospital Drive
Spruce Pine, NC 28777
(828) 766-7778
(828) 766-7780 fax

BHC
71 Blue Ridge Lane
Burnsville, NC 28714
(828) 682-8588
(828) 489-3440 fax


## 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 MCHP | NAME OF PERSON/ORGANIZATION/FACILITY Joshua Newton, PA-C |
| ADDRESS 86 N Mitchell Ave | ADDRESS 167 Locust Avenue suite 216 Spruce Pine, NC 28777 |
| CITY/STATE/ZIP Bakersville, NC 28705 | CITY/STATE PHONE#: 828-239-9[illegible] FAX#: 828-340-1791 |

**The purpose or need for this disclosure is**

Transfer of care

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. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record.) Release of psychotherapy notes requires a separate authorization. **Information to be disclosed:** *(check appropriate box(es))*

- [X] Entire medical record
- [ ] Only information related to *(specify)*: _____
- [ ] Only the period of events from: _____ to _____
- [ ] Exclusions
  - __AIDS/HIV test results, diagnosis, treatment, and related information
  - __Drug screen results and information about drug and alcohol use and treatment
  - __Genetics testing
  - __Mental Health Notes

I understand that this authorization will expire one year 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 MCHP Privacy Officer 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 MCHP 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.*