Physicians East, P.A.
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Chart Number: _____

Information to be disclosed/released: (Check information to be disclosed/released)

☐ Office Visit Notes ☐ Consultation Reports ☐ Laboratory Results ☐ Diagnostic Reports ☐ Procedure Reports ☐ Radiology Reports

☐ Billing Information ☐ CD of Diagnostic Image ☐ Immunizations ☐ Other (please specify): _____

Purpose: ☐ Continuity of Care ☐ At the Request of the Individual ☐ Transfer of Care ☐ Legal/Insurance ☐ Other: _____

****Purpose is not required if patient is obtaining a copy of the record for his/herself.**

Authorization: I request and authorize Physicians East to: ☐ send/provide records/information to ☐ receive records/information from

Facility/Individual: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Fax Number: _____

This information will cover the period(s) of healthcare from _____ to _____.

Date **Date**

Format to be sent: Electronically: via ☐ CD ($6.50 charge) ☐ USB ($6.50 charge) ☐ Portal (patient requests to receive information only-no charge**)** ☐ Email (record address-no charge:) _____. I understand sending email over the internet is not secure. I understand there is a possibility that information included in an email can be intercepted and read by others beside the person whom it is addressed. I have been informed of the risks and still wish the information to be provided via email to the address noted above.

☐ Paper (charge based on actual costs of supplies, postage (if mailed) and labor.)

There is no charge for sending patient information to another healthcare provider, regardless of format chosen.

Provide information by: ☐ Fax to the number noted above ☐ Mail/Email to the address noted above ☐ Call for pick up

I understand this authorization can be revoked by writing to the Physicians East, P.A. Privacy Officer or filling out a form (Ref. FM0018) at any time, except to the extent that action has been taken in accordance with this authorization. Unless otherwise revoked, this authorization will expire in:

☐ 90 days; ☐ one year; ☐ other: (can not exceed one year) _____. If I fail to specify an expiration date, this authorization will expire one year from the date on which it was signed.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand information released may be related to HIV/AIDS, communicable/sexually transmitted diseases, drug testing information, mental health, substance and/or alcohol use, treatment for abortion and/or contraceptive management or genetic testing. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. All requests will be handled within 30 days.

Patient Signature: _____ Date: _____

Personal Representative Signature (if not the patient): _____ Date: _____

Printed Representative's Name: _____ Relationship to Patient: _____

Physicians East Representative Signature: _____ Date: _____

Printed Physician East Representative Name: _____

A Notary Public must witness the patient/personal representative's signature on request not completed at Physicians East. This is not required if the patient is requesting a copy for his/herself.

Notary Public: _____ Date: _____

Sworn to and subscribed before me this _____ day of _____ 20____.

My commission expires: _____.

PE Authorization to Release Health Information
Revised: 10/2017
Original: PE Record
Copy: Patient

Physicians East
1850 West Arlington Blvd
Greenville, NC 27834
Phone: 252-752-6101
Fax: 252-752-7781