AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

RC0200

(identification)

BalladHealth™

Patient Name	Birth Date	Social Security No. (Last 4 digits)
Address		Telephone No. ( )

I hereby authorize _____ to
Facility Name

❑ Disclose or ❑ Obtain information from the medical records of _____
Patient Name

❑ To or ❑ From _____
Name/Address of Person/Organization to which disclosure or request is to be made

_____

For the following purpose: _____

For treatment dates: _____
Specific dates must be indicated

Type of Access Requested

- ❑ Paper copies of the record
- ❑ Inspection of the record
- ❑ Ballad Health electronic thumb / jump drive
- ❑ E-mail address

_____

Description of Information to be Used / Disclosed

- ❑ Physician/Clinic Office Records
- ❑ Abstract
- ❑ Emergency Room
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Consultation
- ❑ Operative/Procedure Report
- ❑ Lab
- ❑ Radiology
- ❑ Cardiac Studies/EKG
- ❑ Pathology
- ❑ Nursing Notes
- ❑ MD Progress Notes/Orders
- ❑ Entire Record
- ❑ Other _____

Expiration Date: ____/____/____ OR Expiration Event: _____
(Note: Date or Event not to exceed one year from date of signature.)

_____ Initials I acknowledge, and hereby consent to such, that the released information may contain psychiatric, alcohol, drug abuse, HIV testing, HIV results, or AIDS information.

_____ Initials I acknowledge, and hereby consent to such, that there is a level of risk that my unencrypted PHI could be read or otherwise accessed by a third party while in transit via unencrypted email. Further I understand that I am directing the organization to comply with my request to send my PHI via unencrypted email.

In workers' compensation cases, this medical authorization form only permits the employer or the division of workers' compensation to obtain medical information through oral or written communication, including, but not limited to, charts, files, records, and reports in the possession of a medical provider authorized by the employer pursuant to T.C.A. § 50-6-204 and a medical provider that is reimbursed by the employer for the employee's treatment.

State of Virginia, § 65.2-604. Furnishing copy of medical report: 1) Any health care provider attending an injured employee shall, upon request of the injured employee, employer, insurer, or a certified rehabilitation provider as provided in Article 2 (§ 54.1-3510 et seq.) of Chapter 35 of Title 54.1 providing services to the injured employee, or of any representation thereof, furnish a copy of any medical report to the injured employee, employer, insurer, or a certified rehabilitation provider as provided in Article 2 (§ 54.1-3510 et seq.) of Chapter 35 of Title 54.1.

Worker's compensation records to be released is limited to the treatment records for worker's compensation injury only.

I understand that I may revoke this authorization at any time by notifying in writing the Medical Record Department of this Ballad Health facility or Ballad Medical Group office. Such notice will not affect any actions already made prior to this authorization. I understand that my healthcare, payment for my healthcare, enrollment or eligibility of benefits will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

Time/Date	Signature of Patient/Parent/Conservator/Guardian	Printed Name	Relationship to Patient
Time/Date	Signature of Witness	Photo ID Provided	
Time/Date	Team Member who Processed Release		

Fees/charges will comply with all laws and regulations applicable to release of information.

KEY: MD=Medical Doctor, PHI=Personal Health Information, EKG=Electrocardiogram, HIV=Human Immunodeficiency Virus, AIDS=acquired immune deficiency syndrome