Cherokee
HEALTH SYSTEMS

For Office Use Only
Chart #:

Authorization to Release and/or Obtain Health Records

Patient Information:

Enter Your personal Information in this section

Name: ______________________

Phone Number: ______________________ Address: ______________________

City: ______________________ State: ____________ Zip: ____________

Record Requested to be Sent From:

You are authorizing Cherokee Health to obtain records from the following Healthcare provider

Facility Name: ______________________

Phone Number: ______________________ Addre...

City: ______________________ State: ____________ Zip: ____________

Record to be Sent To:

You are authorizing Cherokee Health to send your medical records to this Healthcare Provider

Facility Name: ______________________

Phone Number: ______________________

City: ______________________ State: ____________ Zip: ____________

Records Requested*: **Record Request Dates:** ***From:*** __________ ***To:*** __________

- ☐ Medical Records
- ☐ Behavioral Health Records
- ☐ Substance Use Disorder Treatment Records
- ☐ Other (Please Specify) ______________

* I understand and agree that the records I authorize for release may include information that could be considered information about family planning services and communicable disease; which may include, but is not limited to: hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I understand that my substance use disorder treatment records, if any, are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise required for by the regulations, by other applicable law, or by an Order of a court. I also understand that by authorizing release of Medical Records, there may be some limited information included about substance use and/or behavioral health diagnosis and treatment in the medical record.

Purpose:

- ☐ Personal Use
- ☐ Legal
- ☐ Disability
- ☐ Coordination of Care
- ☐ Transfer of Care
- ☐ Other ______________________

Patient Signature:

I hereby certify that I am: 1. At least 16 ... if requesting Behavioral ... 18 years of age if requesting Medical records, or 2. The parent, ... f age if requesting Behavioral Health and/or Substance Use Disorder Reco... 3. The conservator or guardian for the service recipient, or 4. The guardian-ad-lite... which the guardian-ad-litem serves, or 5. The attorney-in-fact under a power of ... wer for the service recipient, or 6. The executor, administrator, or personal represe... nd this authorization is valid for 12 months from the date of signature and that I m... but that it will not affect any information released prior to written notification of cancellation.

Be sure to Sign and Date before sending to Cherokee Health or Vital Records Control

Printed Name: ______________ Authorized Signature: ______________ Date: ____________

Relationship to Patient:

- ☐ Self
- ☐ Other: ______________________