Authorization for Release of Medical Information

BalladHealth

Patient Identification

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.

❑ **For Substance Use Disorder Records:** To my treating providers, health plans, third party payors, and people helping to operate this substance use disorder program for treatment, payment, and healthcare operations for any and all dates of service.

Note: These records may be re-disclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient

Type of Access Requested	Description of Information to be Used / Disclosed		
❑ Paper copies of the record	❑ Entire Record	❑ Abstract	❑ Cardiac Studies/EKG
❑ Inspection of the record	❑ Consultation	❑ Discharge Summary	❑ Emergency Room
❑ Ballad Health electronic thumb /jump drive	❑ History & Physical Records	❑ Lab	❑ MD Progress Notes/Orders
❑ Secure e-mail (requires a login)	❑ Nursing Notes	❑ Operative/Procedure Report	❑ Pathology
❑ Unencrypted email (initial the space below)	❑ Physician/Clinic Office Records	❑ Radiology	❑ SANE Record
		❑ Substance Use Disorder	❑ Other _____

Expiration Date: ___/___/_____ OR Expiration Event: _____

_____ 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 — If I selected access through unencrypted email, I acknowledge and accept, that there is a risk that my unencrypted medical information could be intercepted and read by an unauthorized person.

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 are 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 revocation will not affect future uses and disclosures to the extent that Ballad Health has already acted in reliance on my prior 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 unless this form is being used for my consent to use and disclose substance use disorder records for payment purposes. If I am receiving services from a substance use disorder program, I understand that I will not receive treatment unless I authorize disclosure of my substance use records to my health plan or a third-party payer for purposes of the program receiving payment. 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.

Time/Date	Signature of Patient/Parent/Conservator/Guardian	Printed Name	Relationship to Patient
Time/Date	Signature of Patient/Parent/Conservator/Guardian	Printed Name	Relationship to Patient
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