PART A: PATIENT INFORMATION

Patient: Name: Phone: Email:

Address:

Date of Birth: SS# (last 4 digits):

PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

☐ Self (same info as above)

☐ Person or Entity:_____ Phone:_____ Email: _____

Address: _____

PART C: INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

☐ Abstract/Summary (Discharge Summary, History and Physical, Consults, Operative/Procedure Reports, ED Notes, Laboratory Reports, Radiology Reports, Pathology Reports)	☐ Discharge Summary	☐ Radiology Reports	☐ Clinic Visit- (Specify Clinic)	☐ Entire Record
	☐ History and Physical	☐ Radiology Images		
	☐ Consultation Report	☐ PT/OT		☐ Billing Records
	☐ Operative Report	☐ Emergency Dept. Record	☐ Other-(Please Specify)	
	☐ Laboratory Reports	☐ Pathology Reports		

Treatment Location:

☐ All Granville Health System Entities	☐ Granville Behavioral Health	☐ Granville Gastroenterology Associates	☐ Granville ENT
☐ Granville Medical Center / EMS	☐ Granville Heart & Vascular	☐ Granville Urology Associates	
☐ Granville Primary Care & OB/GYN	☐ Granville Primary Care- Butner/Creedmoor	☐ Granville Surgical Associates	
☐ Granville Orthopedics	☐ Granville Medical Rehabilitation	☐ Brantwood Nursing & Rehab Center	

Treatment Date(s):

☐ From _____ to _____ (please be specific) ☐ All Treatement Dates

PART D: PURPOSE OF REQUEST

☐ Personal ☐ Legal ☐ Insurance ☐ Continuation of Care ☐ Other (specify)

PART E: FORMAT AND DELIVERY OF INFORMATION

Format (select only one)	Other	Delivery Method (select only one)
☐ Paper ☐ Encrypted Email ☐ CD	☐ Oral Communications	☐ Electronic (Encrypted Email)
☐ Fax ☐ Thumb drive (flash drive)		☐ Mail
		☐ In-Person Pick up (Name: _____)

PART F: REVIEW AND APPROVAL

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. **I specifically approve the release of the following information that has been marked as sensitive and/or restricted. (check all that apply): ☐ Mental and Behavioral Health ☐ Substance Use Disorder ☐ Genetic Testing**. I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, Granville Health System will continue to provide treatment and seek payment for services provided. Granville Health System may charge a fee for providing the information specified above.

This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here_____

Signature Printed Name Date

Witness Signature ID # Date

PART G: REPRESENTATIVE (COMPLETE IF SIGNED BY PERSONAL OR AUTHORIZED REPRESENTATIVE)

Representative Full Name (print) Relationship to Patient: Phone Number:

If you are not the patient or the parent of a minor patient, you MUST attach documentation of your authority to act on behalf of the patient. Select all information attached: ☐ Power of Attorney ☐ Court Order ☐ Legal Guardian Documentation ☐ Executor/Administrator Documentation

Granville HEALTH SYSTEM

Granville Medical Center
P.O. Box 947 • Oxford, NC 27565-0947

AUTH FORM

Authorization for Use and/or Disclosure of Information