The Pisgah Institute for Psychotherapy & Education, P. A.
158 ZIllicoa Street Asheville, NC 28801

Office (828) 254-9494 Fax (828) 250-0890

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

This form permits **The Pisgah Institute** to request and/or release the patient's information for the purpose(s) described below.

Patient Name: _____ Date of Birth: _____

RECIPIENT(S): check the appropriate box for TPI to obtain and/or release information

☐ I authorize The Pisgah Institute to **disclose/release information to:**
☐ I authorize The Pisgah Institute to **obtain information from:**

Practice/Individual: _____

Address, City, State, Zip: _____

Phone: _____ Fax: _____

When releasing records to TPI, send records to: Fax 828-250-0890 or 158 Zillicoa Street Asheville, NC 28801

CHECK THE TYPE OF INFORMATION TO BE RELEASED AND/OR OBTAINED:

☐ Entire record
☐ Verbal communication
☐ Records from _____ to _____
☐ Office visit notes
☐ Lab/diagnostic results related to: _____
☐ Other (describe): _____

Do not include: ☐ HIV and/or AIDs related information ☐ Alcohol/drug abuse treatment ☐ Genetic testing results ☐ Other: _____

Purpose of Release: ☐ Personal Use ☐ Coordination of care ☐ Transfer of care ☐ Legal/Court matter ☐ Insurance ☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- I understand that The Pisgah Institute is NOT required to obtain authorization to share my Protected Health Information for most purposes related to treatment, payment, or health-care operations.
- I understand that I have the right NOT to authorize release of my Protected Health Information for purposes other than treatment, payment, or health care operations.
- I understand that if Protected Health Information disclosed pursuant to this authorization is redisclosed by the recipient, it may no longer be protected by the HIPAA Privacy Rule.
- I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol or other substance abuse, or psychological or psychiatric conditions, this disclosure will include that information unless I exclude it above.
- I agree to hold The Pisgah Institute harmless if any Protected Health Information transmitted does not reach the authorized recipient.
- I understand medical record requests may take up to 30 days.
  I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year unless I specify otherwise: _____

_____ _____
Patient or Personal Representative Signature **Date**

_____

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney).

Attach documentation to support the personal representative's authority if not already on file with the practice.