CENTRA

Centra Release of Information
2010 Atherholt Road
Lynchburg, VA 24501
Phone: (434) 200-4506
Fax: (434) 200-6064

Authorization to Release Protected Health Information

Patient Name:_____ Social Security # (last 4 digits):_____

Address:_____

Date of Birth:____/____/____ Date of Service:_____ Phone #:_____

I hereby authorize Centra to use and **DISCLOSE TO:** ☐ or **OBTAIN FROM:** ☐ or **PATIENT REQUEST OF RECORDS** ☐

_____ _____

Name of Facility or Person **Phone #**

_____

Street Address **City** **State** **Zip Code**

The following information will be released OR is being requested:

☐	**Complete Record**	☐	Family / Social Support	☐	Pathology Report	☐	Recommendation for Placement
☐	Academic / Behavioral Info	☐	Immunization Record	☐	Physician Orders	☐	Rehabilitation Reports
☐	Aftercare Planning	☐	Involvement in Care Activities	☐	Physician Progress Notes	☐	Report Cards
☐	Billing Summary / Records	☐	Lab Results	☐	Progress in Treatment (clinical)	☐	Social History
☐	Consultation Reports	☐	Medical History & Physical	☐	Progress in Treatment family)	☐	Therapy Records
☐	Diagnostic Tests / Reports	☐	Medication(s)	☐	Progress Notes	☐	Transcript
☐	Discharge Summary	☐	Mental Status Examination	☐	Psychiatric Admission Note	☐	Treatment Plan / Recommend
☐	Education Evaluation	☐	Neuropsychological	☐	Psychiatric Discharge	☐	**Other:**
☐	Educational Plan	☐	Nurse Notes	☐	Psychiatric Evaluation		
☐	Emergency Dept Report	☐	Operative Summary	☐	Radiology Reports / Images		

The purpose for the release of information at the request of the individual is:

☐ Insurance ☐ Legal Action ☐ Continued Treatment ☐ Personal Use ☐ Education

☐ Other (specify)_____

Format for Records: ☐ Paper ☐ Electronic (CD) ☐ Secure email to:_____(email address)

If you are requesting paper or an electronic CD of records, please indicate: ☐ **MAIL or** ☐ **PICK-UP**

Unless the format for records is indicated specifically above, the above information may be shared verbally, or in written or electronic form. I understand that information disclosed pursuant to this authorization may be released or distributed by the recipient and may no longer be protected by HIPAA. Sensitive records, such as those related to mental health, alcohol or substance abuse treatment, HIV/STDs may be included in the released records/ information. Except to the extent that Centra or other lawful holder of my records/information has already acted in reliance upon it, this authorization is subject to revocation at any time by sending written request to Centra Release of Information. Attn: Privacy Officer, 2010 Atherholt Road, Lynchburg, VA 24501. Otherwise, this authorization will automatically expire upon the earlier of my death or the following date/event entered here:_____

As the person signing this authorization, I understand that I am giving my permission to the above-named entity for disclosure of confidential health records. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health record. I may refuse to sign this form. I understand that Centra will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of this authorization.

I understand there may be a charge assessed as a result of this request consistent with Centra policy.

NOTICE TO RECIPIENT OF RECORDS: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.21(c)(5) and 2.35.

_____

Signature of Patient or Legal Representative **Date / Time**

☐ Parent or Legal Guardian ☐ Power of Attorney ☐ Next of Kin Deceased ☐ Administrator of Estate

Patient Label