# Carolina Mountain Gastroenterology

a Division of Digestive Health Partners, P.A.

## Consent for Release of Personal Health Information (PHI)

Patient Name: _____

Address:_____

Phone: _____ Date of birth: _____

| □ **Obtain From** □ **Send to** | □ **Obtain From** □ **Send to** |
|---|---|
| Carolina Mountain Gastroenterology | Name/Office: _____ |
| 1032 Fleming Street | Address: _____ |
| Hendersonville, NC 28791 | City/State/Zip: _____ |
| Fax: 828-696-3868 | Fax: _____ |
| Office: 828-696-3099 | Office: _____ |

**REQUESTED RECORDS:**

☐ Send all my records

☐ Send only records requested: _____

**REASON FOR REQUEST:**

☐ Transfer of care ☐ Referral appointment ☐ Insurance request

☐ Worker's Compensation ☐ Other: _____

**METHOD OF REQUEST:**

☐ I will pick up my records, please call: _____

☐ Please mail my records to address listed above

☐ Please fax my records to facility listed above

Patient signature: _____ Date: _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous records from other practices and practitioners, hospitals, and/or clinics which are part of my medical records. This authorization includes consent for the release of alcohol, drug, psychiatric, and psychological information; and information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and AIDS related syndromes. It also includes information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as the original release.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent, and prior to any service being provided to you by the practice. The Practice reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer or by asking the provider's receptionist. You can also obtain a copy on the clinic's website at www.caromtngastro.com.

By signing this form, you acknowledge that you have been given the opportunity to read the clinic's Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations. You have the right to revoke this consent in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA), and Health Information Technology for Economic and Clinical Health Act (HITECH).