



Centra Release of Information
 2010 Atherholt Road
 Lynchburg, VA 24501
 Phone: (434) 200-3144
 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

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 Centra #999-2596
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