Blue Ridge MEDICAL CENTER

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CONSENT TO EXCHANGE MEDICAL, BEHAVIORAL HEALTH AND DENTAL RECORDS

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide and coordinate these services or benefits.

A SEPARATE FORM must be completed for EACH PROVIDER with whom you are requesting records be exchanged!

Patient Name	Date of Birth	Social Security Number
Address		Phone number
Person giving consent	Relationship to patient ☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney	

I want Blue Ridge Medical Center and the following agency to exchange this information:	
Address	Phone

The items checked below indicate the confidential information about the patient to be exchanged for dates: _____to_____

Medical/Dental:

☐ All Records ☐ Office Notes ☐ Medical diagnoses ☐ Out Patient Records ☐ Admission Reports

☐ Labs ☐ Medical Imaging ☐ Discharge Summary ☐ Pharmacy Records ☐ Emergency Department Report

☐ Immunizations ☐ Physical Therapy ☐ Dental Records & Imaging

Behavioral Health:

☐ Assessments ☐ Psychiatric Records ☐ Mental health diagnoses ☐ Psychological Records ☐ Criminal Justice Records

☐ Substance abuse/HIV or Hepatitis Information

Other:

☐ Educational Records ☐ Social/family history ☐ Billing Records ☐ Other: _____

I want the information exchanged ONLY for the following purpose(s) (Check all that apply):

☐ Assessment and evaluation ☐ Service coordination, referral & treatment ☐ Eligibility determination ☐ Insurance ☐ Attorney

☐ Self/personal copy ☐ Transfer/continuity of Care ☐ Other:_____

I want the following types of information to be shared (Check all that apply):

☐ Written information ☐ Computerized Data ☐ Verbal, Meetings or Phone

This consent is good for one year from the date of signature.

I understand that: I can withdraw this consent at any time by submitting my request to the appropriate agency in writing. This will stop the listed agencies from sharing information after they know my consent has been withdrawn: I have the right to know what information about me (or my child) has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information; I want all agencies to accept a copy of this form as a valid consent to share information. *If I do not sign this form, information will not be shared and I will have to contact each agency to give them information about me (or my child) that they need.*

Signature _____ Date _____

☐ I request that someone explain this form to me.

Person Explaining Form _____ Date_____ Witness (if required) _____ Date _____

Notice: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibits a recipient from making any further disclosure of alcohol or substance treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 3. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 CFR limits those who may act in place of the client who has been adjudicated mentally incompetent to individuals who have been appointed the client's legal guardian. 42 CFR permits limited disclosures about deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death. Any other disclosure of information identifying a deceased client as an alcohol or drug abuser is subject to the 42 CFR.