AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:	Date of Birth:
Address:	Last 4 of SSN:
City, State, Zip:	Phone: ( )
E-mail:	

RELEASE FROM (check all that apply):	**RELEASE TO**:
☐ Monarch (all locations, ***except*** those listed below) ☐ DWI Program or MAT Program ☐ Tanglewood Arbor	Name of Individual: Name of Organization: Street Address or P.O. Box: City, State, Zip: Fax: E-mail:

REASON FOR RELEASE (check all that apply):

☐ Personal ☐ Legal ☐ Continued Patient Care

☐ Insurance ☐ Personal Injury/Social Security ☐ Workers' Compensation

☐ Other (specify):

DATES OF RECORDS TO RELEASE (check one):

☐ All Dates ☐ From ____/____/_____ to ____/____/_____

WHAT TO RELEASE (check all that apply):

☐ All Records (not including psychotherapy notes) ☐ Comprehensive Clinical Assessments ☐ Dates/Times/Locations of Treatment

☐ Discharge Summaries ☐ Medication Reports ☐ Service Notes

☐ Other (specify):

DELIVERY METHOD (check one; charges may apply):

☐ U.S. Mail ☐ Encrypted E-mail (this may require setting up an account) ☐ Fax

☐ Other (specify):

I understand that:

- I can cancel this authorization at any time. I must cancel in writing and send or deliver the cancellation to Monarch. Any cancellation will apply only to information not yet released by Monarch.
- This is a full release, including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here: _____

If you are requesting your own records:	**If you are requesting records on behalf of another person:**
Signature:	Signature:
Print Name:	Print Name:
Date:	Date:
	Relationship to Patient (written proof may be required): ☐ Parent/Guardian ☐ Executor/Administrator ☐ Healthcare Agent ☐ Other (specify):

Please return completed Authorizations to Monarch's Medical Records Department: mailing address: 350 Pee Dee Avenue, Suite 101, Albemarle, NC 28001; e-mail: medicalrecordsrequest@monarchnc.org (please note that unencrypted e-mail may not be secure); fax: (844) 892-3419; or drop them off at any Monarch location.