REV: 08/17/2023

HIGH COUNTRY community health

FAX 828-733-7197 / E-FAX 855-865-3651
Ph (828) 737-0221

Authorization to Disclose Protected Health Information

Patient Name: _____ **Phone #:** _____
Date of Birth:_____ **Address:** _____

I authorize High Country Community Health to release protected health information to the following individual(s) / organization (s):

Name/Organization: _____Avery County Schools_____
_____
_____

I authorize High Country Community Health to obtain protected health information from the following organization(s):

Name/Organization: _____Avery County Schools_____
_____
_____

I understand that I am authorizing my entire medical record to be released or obtained by High Country Community Health including the reports checked below: (please only check reports you want to release)

Type of report	
Psychological and mental health testing or treatment, including substance use (if applicable)	
Other (Specify):	

I understand that it is my responsibility to notify High Country Community Health if I wish to cancel this authorization. I further understand that High Country Community Health is not responsible for disclosures made based on this authorization prior to the date of cancelation. This authorization will expire one year from the date this form is completed

Patient Signature (if over 18): _____ **Date:** _____

****Patient/Legal Representative signature (if patient is a minor):**_____

Relationship to patient: _____