TRELLIS Supportive Care
Palliative • Hospice • Family Support

Trellis Supportive Care Grief Counseling Services Patient Authorization Form

Patient Name: _____Date of Birth: ____/____/_____ Patient #_____

I voluntarily authorize Trellis Supportive Care to disclose my health information to:

Name of person or institution: _____

Address: _____City: _____ State: ____Zip: _____

Email Address: _____ Phone Number: _____Fax Number: _____

I authorize the release of my health information for the following dates of service:

☐ All dates of service ☐ Dates of Service from _____ to _____

I authorize the release of my health information:

☐ Grief Counseling Record ☐ Summary of Grief Counseling Services ☐ Other_____

I understand that these records may include information related to the following conditions:

- Psychological, psychiatric, or other mental impairments
- Drug abuse, alcoholism, or other substance abuse.
- Communicable or venereal diseases which may include, but are not limited to, hepatitis, syphilis, gonorrhea, HIV, AIDS and tests for HIV.

I authorized my health information to be disclosed for the following purpose(s).

☐ Insurance Coverage/Reimbursement ☐ Personal Representative Request ☐ Medical Provider(s)

☐ Legal ☐ Other: _____

Disclosure Format:

☐ US Mail -Paper format ☐ Fax ☐Flash Drive ☐ Secure Email

☐ Unsecure Email (Unencrypted)

I understand that transmission of unencrypted email over the internet is at risk for interception by unauthorized individuals and is not recommended. I request an unencrypted email and accept the risk. _____ (Initial)

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocations must be made in writing and presented or mailed to the Privacy Officer at the following address: 101 Hospice Lane, Winston-Salem, NC 27103. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Print Name Relationship to Patient (if applicable)

If you are not the patient, you MUST attach documentation of your authority to act on behalf of the patient.

Please send complete authorization to:

Mailing Address: Attention: Medical Records, Trellis Supportive Care, 101 Hospice Lane, Winston-Salem, NC 27103

Email: medicalrecordrequest@trellissupport.org**Fax Number:** 336-673-6025 **Phone Number:** 336-331-1258