| **AUTHORIZATION TO SEND MEDICAL RECORDS TO GALATIANS COMMUNITY HEALTH**  *AUTORIZACIÓN PARA ENVIAR REGISTROS MÉDICOS GALATIANS COMMUNITY HEALTH* |
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***\*\*Complete if you have records that need to be sent from your previous provider TO GALATIANS COMMUNITY HEALTH.***

*\*\* Complete si tiene registros que su proveedor anterior deba enviar a GALATIANS COMMUNITY HEALTH.*

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chart:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nombre del paciente*

**Patient’s Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*Dirección del paciente Feche de nacimiento*

**-FROM- PROVIDER BEING ASKED FOR INFORMATION**

***DE:*** *PROVEEDOR QUE SE SOLICITA INFORMACIÓN*

**Provider Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nombre del proveedor*

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Dirección*

**PHONE#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Teléfono#*

**FAX# if known:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Número de fax si se conoce*

**I request & authorize the provider above to release the following health information concerning me:**

*Solicito y autorizo ​​al proveedor anterior a divulgar la siguiente información médica sobre mí:*

**-TO- GALATIANS COMMUNITY HEALTH** ● **4551 NEW BERN AVE, STE 160, RALEIGH, NC 27610**

**FAX** ● **919-556-6099**

* **Send only my records from (Date) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to (Date) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

*Enviar solo mis registros de (Fecha) a (Fecha)*

* **Send ONLY the following specified records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Envía SOLO lo siguiente registros especificados*

* **Send ALL MEDICAL RECORDS /** *Enviar TODOS LOS REGISTROS MÉDICOS*

**The purpose of releasing this data shall be / *Este propósito de divulgar estos datos será:***

* Continued medical treatment / *tratamiento médico continuado*
* Personal
* Second opinion / *segunda opinión*
* Change of insurance / *cambio de seguro*
* Transfer of care / *transferencia de cuidado*
* Other / *Otro:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken. This consent will automatically expire after 90 days from the date on which it is signed.**

*Entiendo que puedo revocar este consentimiento en cualquier momento, excepto en la medida en que ya se hayan tomado medidas basadas en este consentimiento. Este consentimiento caducará automáticamente después de 90 días a partir de la fecha en que se firme.*

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| ***SIGNATURE:*** *(Patient, Parent, Legal Guardian, Legal Custodian or person standing in loco parentis)*  ***FIRMA:*** *(Paciente, Padre, tutor legal, custodio legal o persona in loco parentis)* | ***DATE***  *Fecha* |