Psychiatrist OR
Therapist OR
HOSPITAL (ED)

**THIS FORM SHOULD ONLY BE USED WHEN REQUESTING HEALTH INFORMATION FROM AN OUTSIDE HEALTH CARE PROVIDER FOR CONTINUITY OF CARE**

## REQUEST FOR EXTERNAL RECORDS

### PART A: PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Phone: | Email: |
| Address: | | |
| Date of Birth: 12/01/2007 | SS# (last 4 digits): | Medical Record #: |

### PART B: REQUESTING INFORMATION FROM / SENDING INFORMATION TO:

| | | |
|---|---|---|
| Outside Health Care Provider: | | |
| Name: | Phone: | Email: |
| Address: | | Fax: |

### PART C: SENDING INFORMATION TO / SENDING INFORMATION TO:

| | | |
|---|---|---|
| Granville Health System Provider: GRANVILLE BEHAVIORAL HEALTH SERVICES | | NPI 1710069164 |
| Name: STEPHAN BAUM, MD / APRIL WELBORN, MD | Phone: 919-690-3217 | Email: bhealth@granvillemedical.com |
| Address: 102 Professional Park, PO Box 947, Oxford, NC 27565 | | Fax: 919-690-3218 |

### INFORMATION TO BE RELEASED (check all that apply)

**Records or Information:**

| | | | | |
|---|---|---|---|---|
| ☐ **Abstract/Summary** (Discharge Summary, History and Physical, Consults, Operative/Procedure Reports, ED Notes, Laboratory Reports, Radiology Reports, Pathology Reports) | ☒ Discharge Summary<br>☒ History and Physical<br>☒ Consultation Report<br>☐ Operative Report<br>☒ Laboratory Reports<br>☐ Pathology Reports | ☒ Radiology Reports<br>☐ Radiology Images<br>☐ PT/OT<br>☒ Emergency Dept. Record<br>x COMPREHENSIVE CLINICAL ASSESSMENT (CCA) | ☒ **Clinic Visit- (Specify Clinic)**<br>MENTAL HEALTH<br>☐ **Other- (Please Specify)** | ☐ **Entire Record**<br>☐ **Billing Records** |

Treatment Date(s): From _____ to _____ ☐ All Treatment Dates

### PART E: REVIEW AND APPROVAL

The purpose of this release for continuity of care, unless otherwise noted:

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. **I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):**

☒ Mental and Behavioral Health ☒ Substance Use Disorder ☒ Genetic Testing

**This Form will automatically expire one year from the date signed below unless revoked or another date or event is written here**

| Patient or GHS Representative Signature | Printed Name | Date |
|---|---|---|
| | | |

### PART F: REPRESENTATIVE (complete if signed by personal or authorized representative)

| Representative Full Name (please print) | Relationship to Patient | Phone Number |
|---|---|---|
| | | |

**If you are not the patient, parent of a minor patient, or a GHS representative, you MUST attach documentation showing your authority to act on behalf of the patient (Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)**



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