AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Date of Birth:_____

Phone Number:_____

Release From:

Release Records To:

Name_____ Phone _____

Address _____
Street City State Zip

How would I like the records to be released?

☐ Paper copy picked up by _____ (Fee applies)
☐ Mailed to the *Release To* address above
☐ Faxed to provider: _____ _____ _____
Physician Name/Health Care Facility Fax Number Phone Number
☐ Through oral communication with healthcare providers regarding treatment, care or payment.

Purpose:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other (specify)
_____

Treatment Date(s):

☐ Treatment dates from____ to _____ (Please be specific) OR ☐ ALL treatment dates

Information to be Released:

☐ I would like to **review** onsite In the Health information Management Dept., the protected health information for the above dates.
☐ I would like copies of specific reports for the treatment dates listed above (check reports below).

☐ ENTIRE RECORD
☐ Consultation Note
☐ Laboratory Reports

I Understand That:

- **The information to be released may include a diagnosis or reference to the following conditions: medical history, genetic testing.**
- Without my express revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature: My signature is required to validate this Authorization. If I do not sign this authorization, we will still provide treatment and seek payment for services provided. According to the North Carolina General Statutes, Health Information Management may charge for copies of medical records.

This authorization will expire on : **_____**

_____ _____ _____
Signature of Patient/Guardian/Personal Representative Date

_____ _____
Witness Relationship (parent, guardian, etc.)