Authorization for Release of Medical Information

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: ____ S.S. # ______________________________

Date of Birth _____________________ Patient Phone Number(s): ____________________________ MR/Chart Number _________

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

____

____

RELEASE INFORMATION TO: (*recipient of disclosure*)

Name:
Address:
Apt, Suite or PO #:
City, State, and Zip:
Phone:
Fax:

I hereby authorize the use and disclosure of my individual indefinable health information and records as described below:

TREATMENT DATES TO BE DISCLOSED: ____

PURPOSE OF THE DISCLOSURE: Insurance Legal Continuing Care Personal Other (specify) ____________

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:
Rehabilitation/Therapy Radiology Behavioral Therapy Radiology Films All Bills All Records

SPECIFIC INFORMATION TO **NOT** BE DISCLOSED: ____

I Understand That:

- *The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).*
- *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 redisclosure 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, the above referenced medical facility 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.

____ ______________________
PATIENT'S SIGNATURE **DATE**

____ ______________________
PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN **DATE**

____ ______________________
WITNESS **DATE**

Failure to specify an expiration date or event means that this authorization will expire one year from the date on which it was signed.