AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

1920 South 16th Street
Wilmington, NC 28401
Phone: 910-341-3308 Fax: 910-341-3419

SECTION A: Psychotherapy Notes.

☐ Check if this authorization is for psychotherapy notes. **If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information. Identify the psychotherapy notes by checking "Other" in Section C and describing in the space provided, do not check any other boxes or types of information.**

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section C below**.** I understand that this authorization is voluntary.
I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient's Name: ____

Address: ____

City: ______________________ **State**: __________ **Zip Code**: ______________

Telephone: ________________ **E-mail**: ______________________________

Date of Birth: ______________ **Social Security # (last 4 digits only)**: ____________

SECTION C: The use and/or disclosure being authorized.

☐ Present year only ☐ 1 year ☐ 2years ☐ 5year **History/ Office Notes**
☐ Present year only ☐ 1 year ☐ 2years ☐ 5years **Labs**
☐ 2 years **Pap Smears** ☐ 2 yrs **Mammograms**
☐ All **Pathology** reports, All **Colonoscopy** and **EGD** procedure reports
☐ All **Radiologic studies**, **Bone Density Studies**
☐ All **Cardiac Studies**
☐ All **Immunization** reports
☐ All **Hospital Admission History and Physicals**, All **Hospital Discharge Summaries**, All **Hospital Consults**
☐ **Other (please be specific)**

____

Entities Authorized to Use or Disclose:
Records requested **FROM:**
Name of provider or organization:

____

Address ______________________________

____

Phone #: ______________________

Fax #: ______________________

Entities Authorized to Receive and Use:
Records to be **SENT TO**:
Name of provider or organization:

____

Address______________________________

____

Phone #: ______________________

Fax #: ______________________

SECTION D: Purpose of Use or Disclosure of Protected Health Information.

☐ Personal Use ☐ Changing Provider ☐ Insurance ☐ 2nd Opinion ☐ Attorney
☐ At the request of the individual ☐ Other _______________________________

SECTION E: Expiration

This authorization will expire (complete one): ☐ 2 Years after my death
☐ Until I revoke permission in writing ☐ Future Date ____/____/______
☐ On the occurrence of the following event:
____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Wilmington Health Privacy Officer **Telephone:** (910) 796-7701
Fax: (910) 341-3419 **Address:** 1920 South 16th Street, Wilmington, NC 28401
E-mail: privacy @wilmingtonhealth.com

Inability to Condition Treatment: I understand that Wilmington Health may not condition my treatment on my refusal to sign this authorization.

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Signature: ____________________________________ Date: ___________________________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the individual's medical record.