



**AUTHORIZATION for USE, DISCLOSURE and/or
REQUEST of PROTECTED HEALTH INFORMATION**

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

Fax Release Form to: 910-341-3419
Fax Records to: 910-341-1900

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, disclosure and/or request being authorized (minimum necessary).

- Present year only 1 year 2years **History/Office Notes**
- Present year only 1 year 2years **Labs**
- Last **Eye Exam** Last **Foot Exam**
- 2 years **Pap Smears** 2 yrs **Mammograms** All **Immunization** summaries
- All **Colonoscopy** and **EGD** procedure reports All **Pathology** reports
- All **Radiologic studies** (**Bone Density, CT/CTA, MRI/MRA, US, Vascular, etc**)
- All **Cardiac Studies**
- All **Hospital Admissions, H&Ps, Consults, Operative reports, Discharges**
- Other (Please be specific and DO NOT request ALL Records)**

Entities Authorized to Use or Disclose:

Records requested **FROM:**

Name of provider/organization:

Address _____

Phone #: _____

Fax #: _____

Entities Authorized to Receive and Use:

Records to be **SENT TO:**

Name of provider/organization/person:

Address _____

Phone #: _____

Fax #: _____

SECTION D: Preference for Receipt of Records

- Regular Mail Fax:# _____ (Maximum 50 pgs)
- Pick up by: _____ (2-3 day processing minimum) Where: _____
- Retrieve from Website (Personal copies only)
- Electronic Copy (disk)

SECTION E: Purpose of Use, Disclosure and/or Request of Protected Health Information

- Personal Use ***You will be charged a state regulated fee for a personal copy of your records (\$10 minimum/\$50 maximum).**
- Changing Provider/Continuity of Care Insurance Attorney
- Other _____

SECTION F: 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.

SECTION F: SIGNATURE

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION AND THE REQUEST WILL BE CONSIDERED NULL & VOID.

PERSONAL COPIES WILL INCUR A FEE. REFER TO “SECTION E” FOR INFORMATION.

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: _____

WITNESS: _____ **Date:** _____

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