AUTHORIZATION
for USE and/of DISCLOSURE of
PROTECTED HEALTH INFORMATION

4320 Henson Drive
Wilmington, NC 28401
Phone: 910-763-2072 Fax: 910-763-1586

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 information being authorized:

☐ All **Pediatric records (Birth to Present)**
☐ Present year only ☐ 1 year ☐ 2years **Office Notes**
☐ Present year only ☐ 1 year ☐ 2years **Lab Results**
☐ All **Well Child Exams** ☐ Last **Eye/Vision Exam** ☐ Last **Hearing Exam/Test**
☐ All **Immunization** ☐ All **Radiologic studies** ☐ All **Pathology** reports
☐ All **Hospital Admissions, H&Ps**, **Consults**, **Operative Reports, Discharges**
☐ OTHER _____

_____

_____

Entities Authorized to Use or Disclose:	**Entities Authorized to Receive and Use**:
Records requested **FROM:**	Records to be **SENT TO**:
Name of provider or organization:	**Name of provider or organization:**
_____	_____
Address _____	**Address**_____
_____	_____
Phone #: _____	**Phone #:** _____
Fax #: _____	**Fax #:** _____

SECTION D: Preference for Receipt of Records

☐ Regular Mail ☐ Fax:# _____ ☐ Pick up at _____

SECTION E: 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 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.

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: _____

WITNESS: _____ **Date**: _____

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