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.