Wilmington Health | Attn: Medical Records
1202 Medical Center Drive, Wilmington, NC 28401 | Phone: 910-341-3308
Fax: 910-341-1900 | medicalrecords@wilmingtonhealth.com | Upload via patient portal

AUTHORIZATION FOR USE, DISCLOSURE, AND/OR REQUEST OF PHI

PATIENT INFORMATION

Name: _____ DOB: _____ Phone: _____

Address: _____ City/State/ZIP: _____

Email: _____

I HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION:

SENDER OF RECORDS (CHECK ONE)

☐ All Wilmington Health ☐ Only the Specified Provider/Organization/Individual

Name: _____ Phone: _____

Address: _____

City/State/ZIP: _____ Fax/Email: _____

RECIPIENT OF RECORDS (CHECK ONE)

☐ Wilmington Health ☐ Self or Patient Above ☐ To the Specified Provider/Organization/Individual

Name: _____ Phone: _____

Address: _____

City/State/ZIP: _____ Fax/Email: _____

RECORD DELIVERY METHOD / PURPOSE OF RELEASE

Record requests are processed off-site and are unavailable for pickup.

☐ Fax: _____ ☐ Email: _____ ☐ Patient Portal: Data limits may apply.

☐ Mail: Please ensure the address above is complete; large volumes of records will be placed on a disc.

☐ Continuity of care (share for ongoing treatment) ☐ Transfer of care (new provider) ☐ Insurance

☐ Legal ☐ Patient request ☐ Other: _____

RECORDS TO BE RELEASED (CHECK ALL THAT APPLY)

☐ All records ☐ Office notes ☐ Procedure/Operative reports ☐ Lab reports ☐ Pathology/Pap smear ☐ Immunizations

☐ Prenatal records ☐ All radiology reports ☐ Radiology images (processed by Radiology Department)

☐ Please release only specified radiology: _____ ☐ If not indicated above, please specify: _____

DATE RANGE:

☐ All available ☐ Please release only dates: _____

If no date range is indicated, the last three visits will be provided.

AUTHORIZATION, EXPIRATION, AND REVOCATION

This authorization will expire (choose one). If no box is checked, this authorization expires one (1) year from the date signed.

☐ On this date: _____ ☐ When this request is completed.

I may revoke this authorization at any time by sending a written request to Wilmington Health's Privacy Officer, except to the extent action has already been taken in reliance on it. I understand information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected.

By signing below, I authorize Wilmington Health to use and/or disclose my health information as described on this form. This authorization is voluntary and will not affect my treatment, payment, enrollment, or eligibility for benefits.

SENSITIVE INFORMATION

Your records and/or PHI may contain sensitive information protected under state and federal HIPAA laws. If you wish to limit the release of any information, please specify below. If no restrictions are indicated, all records covered by this authorization may be released.

☐ Mental health treatment ☐ HIV status ☐ Substance use treatment

☐ Reproductive health service/genetic testing or other genetic health information

Restrictions or additional information: _____

PATIENT SIGNATURE / DECEASED PATIENT DOCUMENTATION

Patient/Legal Representative Signature: _____ Relationship: _____ Date: _____

I certify that I am the patient's authorized legal representative and have the legal authority to sign this authorization on behalf of the patient. I understand I may be required to provide documentation of this authority upon request.

If the patient is deceased, provide: (1) a copy of the patient's death certificate, and (2) one of the following showing your authority: Letters of Administration, Affidavit of Next of Kin, or other court-issued document appointing you to act for the estate.