Authorization/Consent for Release of Protected Health Information

SECTION A: The person for whom this authorization is being requested. Please complete the following:

Name of patient ______________________ **Prior name(s), if any** ______________________

Social Security Number ______________________ **Date of Birth** ______________________

Street Address ______________________ **City** ______________________

State __________ **Zip Code** __________ **Area Code and Telephone Number** ______________________

SECTION B: Who will provide this information?

The Outer Banks Hospital
4800 S. Croatan Highway
Nags Head, NC 27959

SECTION C: Who will receive this information?

Name/Dept. ______________________

Address ______________________
____

SECTION D: Describe the specific Protected Health Information to be used or disclosed, including date(s):

☐ **Psychotherapy Notes for date(s)** ______________________ IF THIS BOX IS CHECKED, A SEPARATE AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO

☐ **Entire Treatment Record** — **Date(s)** ______________________
☐ **Billing Statements** — **Date(s)** ______________________
☐ **Laboratory Reports** — **Date(s)** ______________________
☐ **Diagnostic Images (X-ray, etc.)** — **Date(s)** ______________________

☐ **Other (Describe)** **Date(s)** ______________________
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____

SECTION E: Describe the reason for the release or request of information:

☐ At the request of the patient/patient representative
☐ Other (state reason:______________________)

SECTION F: By signing below I indicate my understanding that:

- This authorization is voluntary. Treatment or payment will not be affected if I do not sign this form, except as provided by law.
- The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.
- I may revoke this authorization at any time by notifying in writing the entity listed in Section B, but if I do revoke this authorization it won't have any effect on any actions the entity may have taken before it received the revocation.

SECTION G: Expiration and Revocation

This authorization will expire (check one):
☐ On (enter date): ***Or*** ☐ (Enter event or date):

SECTION H: Signature

I hereby authorize the use or disclosure of the Protected Health Information as described above.

______________________ ______________________
Signature of patient or patient's Personal Representative **Date**

______________________ ______________________
Signature of individual releasing requested PHI **Print Name of individual releasing PHI**

SECTION I: If Section H is signed by a Personal Representative, please complete the information below:

Print Representative's Name ______________________ **Relationship to Patient**:______________________

Signature of Person Verifying Representative's Authority: ______________________

Print Name of Person Verifying Representative's Authority: ______________________