

Authorization & Consent for Release of Protected Health Information (PHI)



SECTION A: Who is requesting authorization?

Name of patient _____
 Street Address _____
 City _____
 State _____ Zip Code _____

Prior name(s), if any _____
XXX-XX- _____
 Social Security Number (Last 4 digits only) _____
 Area Code and Telephone Number _____
 Date of Birth _____

SECTION B: Who will provide this information? (Vidant Health Entity, Address & Phone)

Outer Banks Family Medicine - Manteo
604 Amanda Street
Manteo, NC 27954
Phone: 252-473-3478
Fax: 252-473-3600

SECTION C: Who will receive this information?

Name/Dept.: _____
 Address: _____

SECTION D: How will information be sent/received?

- Mail to address in Section C Pick Up
 MyChart. If you have given MyChart proxy access to others, your proxy(ies) will not be able to view the information unless you list here proxies you want to be able to view it: _____
 Email: _____
The risks of electronic transmission of PHI have been discussed.

SECTION E: Describe the reason for the request.

- Attorney/Legal Continued Care
 Personal Use Insurance
 Other: _____

SECTION F: 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 authorize release of any other type of protected health information (phi).*
 Entire Treatment Record Date(s): _____
 Billing Statements Date(s): _____
 Laboratory Reports Date(s): _____
 Diagnostic Images (X-ray, etc.) Date(s): _____
 Other (Describe): _____ Date(s): _____

SECTION G: 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.
- I understand information released may be related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. I also understand that the information may be re-disclosed 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 H: Expiration and Revocation

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

SECTION I: Signature

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

Signature of patient **OR** patient's Personal Representative _____ Date _____ Time _____
 Signature of individual releasing requested PHI _____ Print Name of individual releasing PHI _____

SECTION J: If Section I 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: _____

