

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



## SECTION A: Who is requesting authorization?

Name of patient _____	Prior name(s), if any _____
Street Address _____	Social Security Number (Last 4 digits only) <b>XXX-XX-</b> _____
City _____	Area Code and Telephone Number _____
State _____ Zip Code _____	Date of Birth _____

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

**The Outer Banks Hospital - HIMS**  
**4800 S. Croatan Highway**  
**Nags Head, NC 27959**  
**Phone: 252-449-4520**  
**Fax: 252-449-4521**

## 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).*

<input type="checkbox"/> Entire Treatment Record	Date(s): _____
<input type="checkbox"/> Billing Statements	Date(s): _____
<input type="checkbox"/> Laboratory Reports	Date(s): _____
<input type="checkbox"/> Diagnostic Images (X-ray, etc.)	Date(s): _____
<input type="checkbox"/> 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 <b>OR</b> 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: \_\_\_\_\_

