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

VIDANT HEALTH™

SECTION A: Who is requesting authorization?

Name of patient

Prior name(s), if any

Street Address

XXX-XX-____ Social Security Number *(Last 4 digits only)*

City

Area Code and Telephone Number

State Zip Code

Date of Birth

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

Outer Banks Orthopedics and Sports Medicine
3102 N. Croatan Highway
Kill Devil Hills, NC 27948
Phone: 252-261-9940
Fax: 252-261-9087

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: _____

3195/VH-049