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)* XXX-XX- ___ ___ ___ ___

City ______________________ Area Code and Telephone Number ______________________

State __________ Zip Code __________ Date of Birth ______________________

SECTION B: Who will provide this information?

(*ECU 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: ______________________

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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: ______________________
- ☐ Other: ______________________

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: ______________________

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