NORTH STATE MEDICAL CENTER

Authorization for the Release of Information

I authorize North State Medical Center

OR:

_____

_____

Phone: _____ Fax: _____

To use or disclose to:

Name: _____

Address:_____

City:_____ State: _____Zip: _____

Phone:_____ Fax: _____

The protected health information of:

Patient Name: _____

Date of Birth:_____ SS#: _____

Address:_____

City:_____ State: _____Zip: _____

Phone:_____

Treatment Dates/Type of Service: _____

Information to be Disclosed (please check information requested):

( ) Entire medical record (if checked, everything except Psychotherapy will be included)

( ) Face sheet	( ) Consultations	( ) Medication/graphic sheets
( ) Pathology report	( ) X-ray reports/films	( ) Discharge summaries
( ) Physician orders	( ) Progress notes	( ) History and physical
( ) Emergency Dep't notes	( ) Operative/procedure notes	
( ) Lab reports	( ) Nursing notes	( ) Other

609 Professional Drive
Roxboro, NC 27573
Tel: (336) 599-9257 Fax: (336) 599-1593

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials on the lines below authorize the release (if applicable) of information pertaining to:

_____ Mental health _____ Drug/alcohol use/testing _____Genetic testing

_____ HIV/AIDS and other communicable diseases

The purpose of the use or disclosure is:

_____ Attorney/legal _____ Continued patient care _____ Social services/disability

_____ Personal use _____ Insurance _____ Other:_____

I understand that:

- I may revoke this authorization at any time.
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.
- If I revoke this authorization, I must do so in writing.
- The procedure for revoking this authorization is to present my written revocation to the health information management department.
- I may refuse to sign this authorization.
- North State Medical Center will not condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this authorization.

I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under Federal medical privacy law. I understand that a fee may be charged for copying the protected health information. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date/event/condition, this authorization will expire automatically in ninety (90) days from the date of signature.

Patient Signature (or authorized representative)_____Date_____

Witness Signature:_____ Date_____

Explain the representative's authority to act on behalf of the patient:_____

Date completed:_____By:_____ Total pages:_____Sent via:

( ) Mail ( ) Courier ( ) Certified Mail ( ) Faxed to #:_____ ( ) Pick up ( ) ID checked

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