

Authorization to Disclose Protected Health or Billing Information

Patient Name: Patient Address:

Nickname/Maiden Name/Alias:

Phone #: Medical Record Number:

Date of Birth: To share my health information with:

I give permission to: (Name of Person/Facility)

(Address)

(City, State, Zip)

(Phone number) (Fax Number) (Phone number) (Fax Number)

Check information to be shared:

- Name, Address, Phone Number, Insurance, Social Security #, Entire Medical Record, History & Physical, Laboratory Report, Radiology Report, Radiology Images, Consultation, Physician Dictation, Nurses Notes, Surgery Report, Medication Records, Progress Notes, Discharge Summary, Test Results

Important Notice: This is a full release, including drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:

Treatment Dates (must be a specific date or range of dates)

Check reason to share health information: My (patient) request, Legal, Workers' compensation, Disability, Treatment, Insurance, Other (Describe)

Share Information: In Person, Pick up, Fax, Mail, Other (Describe)

- 1. By law, Novant Health ("Novant") cannot use or share my health information without my permission... 2. I can cancel this permission at any time... 3. I do not have to sign this form... 4. Once information is sent, it may not be protected by law... 5. I have read, understand and, upon my request, been given a copy of this form. 6. This is not for use for Marketing or Research.

NOTICE: There may be a fee charged to make copies of my medical record.

My permission ends 90 days after the date I signed, unless a date or event is written here:

Patient/Patient Representative Signature Date

Legal Authority to sign for patient: Healthcare agent, Guardian, Attorney in Fact, Parent, Next of Kin, Administrator/Executor

If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.

Patient is: Minor, Disabled, Deceased, Incompetent, Incapacitated

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter accepted, Interpreter refused

(Name/number of person/services chosen/used)



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