## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

**Patient Name:** _____ **Date of Birth:** _____

**Address:** _____ **MR#:** _____

_____ **SS#:** _____

I authorize (PROVIDER) _____

_____

to disclose my "protected health information" (PHI) to: _____

_____

_____

Information for treatment period: From (date) _____ To (date) _____

[ ] Entire Medical Record [ ] Laboratory Tests [ ] Pathology Reports [ ] Radiology Reports [ ] Office Notes [ ] H&P Summary
[ ] Discharge Summary [ ] Consultations [ ] Other (please specify) _____

Purpose(s): [ ] Legal Investigation [ ] Insurance [ ] Disability Determination [ ] Change Physicians
[ ] Other (please specify) _____

[ ] I request my information be released to me to exercise my right to access and obtain a copy of my PHI.

- I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.
- I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).
- I understand I may revoke this authorization at any time, however the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Officer to initiate the revocation process.
- I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.
- I understand this Authorization will expire in 90 days after it is signed unless another date is specified here _____.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the patient's behalf. I hereby release **Carolinas Medical Alliance** from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

| Print Patient Name | Patient Signature | Date |
|---|---|---|

_____

| Authorized Representative | Relationship to Patient | Phone # |
|---|---|---|

PROVIDER USE ONLY: Received on _____ Disclosure on _____ Copy to Patient on _____
Disclosure by: _____ Authority: _____