CENTRAL CAROLINA HOSPITAL
A Duke LifePoint Hospital
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For Office Use Only:
Verified: Yes / No
By: _____
D Lic #: _____
SS#: _____
Signature: Yes / No
Team Member: _____
Total Pages: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ **Medical Record # / FIN #** _____

Date of Birth _____

List the specific information that is authorized for disclosure:

Dates of Service / Encounter to be released: _____

☐ Anesthesia	☐ Consultation	☐ Discharge Sum	☐ EKG's	☐ Emergency	☐ Facesheet
☐ History/Phys	☐ Imaging Rpts	☐ Laboratory	☐ Medication	☐ Nursing	☐ Surgery/Proc
☐ Orders	☐ Outpatient	☐ Pathology	☐ Progress Nts	☐ Billing	☐ Echo
☐ Itemized Bill	☐ Acct of Discl	☐ Entire Record	☐ Other	☐ Sleep Study	☐ _____

Name of Recipient:

Enter the name / address / state / zip code and phone number of which the information can be released to.

_____

_____

_____

_____

DESCRIBE THE PURPOSE/REASON FOR REQUEST _____

Your initials are required to release the following information:

	HIV/AIDS Test Results/Treatment		Treatment for Drug, Alcohol, or Substance Abuse Records
	Behavioral health service/psychiatric care		Genetic information (including Genetic Test Results)

I hereby authorize Central Carolina Hospital to use/disclosure my individually identifiable health information in the manner described within this authorization.

I understand that the information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and, depending upon the applicability of federal privacy regulations, may then no longer be protected by those federal regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation to the Release of Information Office at Central Carolina Hospital., except to the extent that Central Carolina Hospital. has taken action in reliance on this authorization. I understand that I may refuse to sign this authorization and if I do, my information will not be used or disclosed for the purposes stated above. I understand that treatment provided by Central Carolina Hospital will not be conditioned upon my signature on this authorization. Unless otherwise revoked, this authorization will expire ninety (90) days from today's date and no further use/disclosure as described above may be made after such expiration. I understand that the person hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization or that refusal to sign this authorization will not affect my treatment.

Patient Signature or * Representative: _____ Date: _____

Relationship to/Authority to act for patient: _____

*** If a patient is a minor or is unable to sign, the legally qualified representative may authorize the release of medical information.**

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