

- PCMH
 Bertie
 Chowan
 Heritage
 OBH
 RCH
 DGH
 SurgiCenter of Eastern Carolina
 Other _____

Authorization/Consent for Release of Protected Health Information

SECTION A: The person for whom this authorization is being requested. Please complete the following:

Name of patient _____ Prior name(s), if any _____
Social Security Number _____ Date of Birth _____
Street Address _____ City _____
State _____ Zip Code _____ Area Code and Telephone Number _____

SECTION B: Who will provide this information?

Pitt County Memorial Hospital
2100 Stantonsburg Road
P.O. Box 6028
Greenville, NC 27835-6028

SECTION C: Who will receive this information?

Name/Dept. _____
Address _____

SECTION D: 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).
- | | |
|--|--|
| <input type="checkbox"/> Entire Treatment Record
<input type="checkbox"/> Billing Statements
<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Diagnostic Images (X-ray, etc.) | Date(s) _____
Date(s) _____
Date(s) _____
Date(s) _____ |
| <input type="checkbox"/> Other (Describe) _____
_____ | Date(s) _____
_____ |

SECTION E: Describe the reason for the release or request of information:

- At the request of the patient/patient representative
 Other (state reason: _____)

SECTION F: 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.
- The PHI used or disclosed may be subject to re-disclose 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 G: Expiration and Revocation

This authorization will expire (check one):
 On (enter date): _____ **Or** (Enter event or date): _____

SECTION H: Signature

I hereby authorize the use or disclosure of the Protected Health Information as described above.

Signature of patient or patient's Personal Representative _____ Date _____

Signature of individual releasing requested PHI _____ Print Name of individual releasing PHI _____

SECTION I: If Section H 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 _____

White Copy: Patient Record Yellow Copy: Patient

2270 – Consent Waiver & Release of Medical Information - PCMH
02/20/09 - XBS

