VIDANT HEALTH™

❑ Vidant Medical Center
❑ Vidant Chowan Hospital
❑ Vidant Medical Group
❑ Albemarle Hospital
❑ Other_____

❑ Vidant Beaufort Hospital
❑ Vidant Duplin Hospital
❑ Vidant Pungo Hospital
❑ Outer Banks Hospital

❑ Vidant Bertie Hospital
❑ Vidant Edgecombe Hospital
❑ Vidant Roanoke-Chowan Hospital
❑ Vidant SurgiCenter

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**
Street Address	**Social Security Number** ***(Last 4 digits only)***
City	**Date of Birth**
State **Zip Code**	**( ) Area Code and Telephone Number**

SECTION B: Who will provide this information? (Vidant Health Entity, Address & Phone)

SECTION C: Who will receive this information?

Name/Dept. _____

Address _____

_____

SECTION D: How will information be sent/received?

☐ **Mail to address listed above** ☐ **Pick Up**

☐ **Electronic (Email)*: _____**

Note: Instructions for electronic access will arrive by email within 3 business days.

SECTION E: Describe the reason for the request.

☐ **Attorney/Legal** ☐ **Continued Care**

☐ **Personal Use** ☐ **Insurance**

☐ **Other: _____**

SECTION F: 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).

☐ **Entire Treatment Record**	**Date(s) _____**
☐ **Billing Statements**	**Date(s) _____**
☐ **Laboratory Reports**	**Date(s) _____**
☐ **Diagnostic Images (X-ray, etc.)**	**Date(s) _____**
☐ **Other (Describe) _____**	**Date(s) _____**

SECTION G: 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.
- I understand information released may be related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. I also understand that the information may be re-disclosed 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 H: Expiration and Revocation

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

SECTION I: 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**	**Time**
Signature of individual releasing requested PHI	**Print Name of individual releasing PHI**	

SECTION J: If Section I 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 _____

Witness Signature	**Witness PRINTED Name**	**Date/Time**