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
❑ 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**

_____ _____
Social Security Number ***(Last 4 digits only)*** **Date of Birth**

_____ _____
Street Address **City**

_____ _____ _____( )_____
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: 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 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.
- 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 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** **Time**

_____ _____
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 _____

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