Please check the box to the left of the appropriate facility / Marque la casilla a la izquierda del centro correspondiente:

- ☐ Brody School of Medicine at East Carolina University
- ☐ Leo W. Jenkins Cancer Center
- ☐ East Carolina Endoscopy Center
- ☐ The Outer Banks Hospital
- ☐ Vidant Beaufort Hospital
- ☐ Vidant Bertie Hospital
- ☐ Vidant Chowan Hospital
- ☐ Vidant Duplin Hospital
- ☐ Vidant Edgecombe Hospital
- ☐ Vidant Home Health & Hospice
- ☐ Vidant Medical Center
- ☐ Vidant Medical Group
- ☐ Vidant Roanoke-Chowan Hospital
- ☐ Vidant SurgiCenter
- ☐ Other / Otro ____________

Authorized Contacts for Protected Health Information (PHI)

Practice Name Vidant Internal Medicine-Greenville

Patient's Name ______________________ Date of Birth ____________

(please print)

Authorized contacts are the people <u>you choose</u> and <u>give us permission</u> to communicate with about your health information or payment for your medical care.

This form allows Vidant Internal Medicine-Greenville ____________ *(practice name entered here)* to provide limited protected health information to your authorized contacts.

You can decide the type of information that we may share with each of them:

(1) your appointments,
(2) your medical information, which includes your treatment and your prescriptions, or
(3) your billing information.

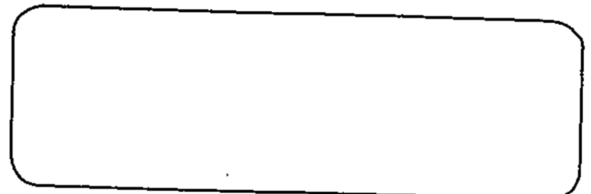
To protect your privacy, please provide the names of people you allow us to communicate with about your care or payment for your care. You can make changes at any time simply by filling out a new form at our front desk. You can also cancel your authorized contacts by giving us a notice in writing.

The Practice is authorized to communicate with the people listed below.

Name	Relationship to the patient	Phone number	What can be released to this person
			Appointment Information Yes No Medical Information Yes No Billing Information Yes No
			Appointment Information Yes No Medical Information Yes No Billing Information Yes No
			Appointment Information Yes No Medical Information Yes No Billing Information Yes No
			Appointment Information Yes No Medical Information Yes No Billing Information Yes No

CONTINUED ON BACK OF THIS PAGE

3151/VH-115



By signing below, I indicate that I understand:

- **I am allowing the disclosure of my protected health information** to individuals I chose as my authorized contacts.
- **I have the right to cancel this authorization at any time by notifying this practice in writing.** I understand that if I cancel this authorization it won't have any effect on any actions the practice may have taken before it received the cancellation.
- **The information shared as a result of this authorization may be re-disclosed by the person who receives the information,** in which case it may no longer be protected under the HIPAA Privacy Rule. This means that any protected health information shared with my authorized contacts may not be protected under the HIPAA Privacy Rule in the future.
- **This authorization is voluntary.** I have the right to refuse to sign this authorization. My treatment or payment will not change if I do not sign this form.

This authorization will be in effect between these dates:

Start date ________________________ and ☐ the end of my treatment at this practice **OR**

☐ date: ____________________________

**The authorization can also be cancelled in writing at any time.*

______________________________	______________	______________
Signature (Patient or patient's personal representative)	*Date*	*Time*
______________________________	______________	______________
Witness Signature	*Date*	*Time*

If the patient's personal representative signed this form:

______________________________	______________________
Print representative's name	*Relationship to patient*

FOR PRACTICE TO COMPLETE:

Representative's authority verified by Risk Management/Legal: ☐

3151/VH-115