Highland Primary Care
515 Suite A Lauchwood Dr., Laurinburg, NC 28352
Office: 910-506-4510 Fax: 910-506-4527

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: ☐ Transfer of Care ☐ Copy of record ☐ Legal or insurance review ☐ Authorized Representative's request
☐ Ongoing communication ☐ Other _____

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information:

Facility/Practice Name: _____ Telephone #: _____

Facility/Practice Address:_____ Fax #:_____
The facility/practice/individual listed above is authorized to release the requested health information for the following date(s) or service, range of time or events:_____ From: (MM/DD/YY)_____ To: (MM/DD/YY)_____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

☐ **All Records & Details**	☐ Discharge Summary	☐ Lab/Pathology Reports	☐ Physician's Orders	☐ **Other (specify) _____**
☐ Appointment information	☐ Emergency Room Records	☐ Medication Records	☐ Progress Notes	_____
☐ Billing Information	☐ History & Physical	☐ Office/Clinic Notes	☐ Psychiatric Evaluation	_____
☐ Consultation Reports	☐ Immunization Record	☐ Operative Reports	☐ Radiology/ Imaging Reports	_____

I understand that the information in my medical record may include information relating to treatment or drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, HIV and/or AIDS.

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patients Name:_____ _____ _____
First MI Last
Patient's Adress:_____

Patient's DOB:_____ Medical Record #:_____ Phone #:_____

Release To: This information may be released to and used by the following individual/organization. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

NAME:_____ ADDRESS:_____ PHONE:_____
_____ _____ FAX:_____
_____ _____ RELATIONSHIP:_____

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department named above in writing. (I understand that revocation will not apply to information that has already been released in response to the authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request or obtain a copy of the information being used or disclosed
- I understand that I **may be charged a fee** for the preparation of the summary or explanation of my protected health information
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document or one year after the date on this release.

PRINTED NAME (Patient/Authorized Representative):_____

SIGNATURE:_____ DATE:_____

RELATIONSHIP:_____

FOR THE PURCELL CLINIC USE ONLY: _____
Initials

☐ IDENTIFICATION VERIFIED ☐COPY OF AUTHORIZATION GIVEN TO PATIENT **DATE OF RELEASE_____**
☐ **MAIL** ☐ **FAX**
- DISC
- PAPER COPY

☐ **PERSONAL PICK UP**