Authorization To Release Personal Health Information

Phone (910) 678-7244
Fax (910)678-7297

Patient Name ______________________________

Date of Birth _________ SSN ________________

Patient Phone Number ______________________

Medical Record Number ____________________

ALL BLANKS MUST BE FILLED IN AND A COPY OF THE FORM GIVEN TO THE PATIENT

I am requesting that:____
(Name of Facility or Physician **RELEASING** Information)

____
Address City State Zip Code (Phone Number)

Send/give Information to:

☐ Southern Regional AHEC
1601 Owen Drive
Fayetteville, NC 28304

☐ ____
____
____

Please include the following information:

☐ **To be Mailed** ☐ **To be Picked Up**

☐ Records for the last 3 years
☐ Lab reports
☐ X-ray reports/films
☐ Other (Please specify information to be released)____

The information is to be used for:____

I understand that my SRAHEC Medical Records may contain records from other facilities and will be sent out when requested.

The Practice is required to respond to you within (30) days of your request to inform you whether it will agree to your request or to inform you if the Practice needs more time to respond to your request.

Pursuant to the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to request that SOUTHERN REGIONAL AREA HEALTH EDUCATION CENTER (the "Practice") provide you with access to your protected health information. The Practice is not obligated to agree with your request in certain instances, including if (i) access to the information raises safety concerns, (ii) access to the information is limited by state law or court order, (iii) the PHI consists of psychotherapy notes, (iv) the PHI was complied by the Practice or one of the Practice's Business Associates in anticipation of or for use in a legal proceeding, (v) the PHI was obtained from someone other than a covered health care provider under a promise of confidentiality and access would likely reveal the source of the information, or (iv) the PHI was created or obtained by a covered health care provider in the course of research and the individual consented to the denial of access when consenting to participate in the research.

CHECK ONE OF THE FOLLOWING BOXES:

I DO ☐ **I DO NOT** ☐ authorize the release of parts of the record that relate to substance abuse, psychological/psychiatric conditions and/or communicable diseases including Acquired Immunodeficiency Syndrome (AIDS) or tests for infection with Human Immunodeficiency Virus (HIV), if present.

CONTINUED ON BACK

I understand that I may take back/cancel this authorization at any time, except to the extent that action based on the authorization has been taken. Unless otherwise designated here: ___________, this authorization will expire automatically after 90 days from the date signed. Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization and it is made voluntarily on my part.

____ ___________________
Signature of Patient or Legal Representative Date

What is your Relationship to the Patient?
☐ Self ☐ Legal Representative ☐ Other ______________________________

____ ___________________
Signature of Witness Date

For Office Use Only
Info Released:

____________ ________
Date Initials

RECORDS MAY NOT BE IMMEDIATELY AVAILABLE THERE MAY BE A CHARGE FOR COPIES
☐ RELEASED AT TIME OF REQUEST ☐ PICTURE ID CHECKED

	Date Sent:

FM 03-30-98 revised 10/6/06