Authorization to Disclose Health or Billing Information

Patient Name:	Patient Address:
Nickname/Maiden Name:	
Date of Birth:	
Medical Record Number:	

I give permission to:	**To release information to:**
(Name of Person/Facility)	(Name of Person/Facility)
(Address)	(Address)
(City,State,Zip)	(City,State,Zip)
(Phone number) (Fax Number)	(Phone number) (Fax Number)

Check Information to Release:

- ☐ Name
- ☐ Address
- ☐ Phone Number
- ☐ Insurance
- ☐ Social Security #
- ☐ Entire Medical Record
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Radiology Images
- ☐ Consultation
- ☐ Other (Describe) ______
- ☐ Nurses Notes
- ☐ Operative Report
- ☐ Medication Records
- ☐ Progress Notes
- ☐ Discharge Summary

Treatment Dates (If Certain Dates are Wanted)_

This is a full release including all drug, alcohol, psychiatric and sexually transmitted disease information unless listed here.

______

Check Reason for Release: ☐ Patient Request ☐ Workers' Compensation ☐ Disability ☐ Treatment ☐ Insurance Other (Describe)

Release Information: ☐ In Person ☐ Pick up ☐ Fax ☐ Mail ☐ Other (Describe)

1. By law, Novant Health ("Novant") can't use or share my health information without my permission except by ways listed in Novant's Notice of Privacy Practices.
2. I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I can't cancel consent for information already shared as a result of this permission.
3. I don't have to sign this form. Refusal won't change my ability to get treatment, payment for treatment or benefits.
4. Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.
5. I have read, understand and been given a copy of this form.
6. This is not for use for Marketing or Research.

NOTICE: I may be charged to copy or mail this information.

Authorization expires 90 days after I sign it unless a date or event is written here: ______

Patient/Patient Representative Signature ______ **Date** ______

Legal Authority to sign for patient: ___ Guardian ___ Administrator/Executor ___ Attorney in Fact ___ Parent ___ Next of Kin

Other (Specify) ______

Patient is: ___ Minor ___ Disabled ___ Deceased ___ Incompetent ___ Incapacitated

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter: ____ Accepted ____ Refused ______

(Name/Number of Person/Services Chosen/Used)

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