

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) | _____ (Phone number) |
| _____ (Fax Number) | _____ (Fax Number) |

Check Information to Release:

- | | | |
|--|---|---|
| <input type="checkbox"/> Name | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Nurses Notes |
| <input type="checkbox"/> Address | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Phone Number | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Radiology Images | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Social Security # | <input type="checkbox"/> Consultation | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Other (Describe) _____ | |

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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