AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Select one: ☐ **MEDICAL RECORDS** ☐ **DENTAL RECORDS** ☐ **BEHAVIORAL HEALTH**

Last Name:_____First name:_____

Date of Birth:_____ Primary Phone: _____

Relationship: ☐ Self ☐ Parent/Guardian ☐ DSS ☐ POA ☐Other: _____

☐ Mark if you want MedNorth to **RELEASE** records to name specified below:

☐ Mark if you want MedNorth to **RECEIVE** records from another Provider/Person below:

Where records are GOING TO OR COMING FROM:

Name: _____

Address: _____

Phone: _____ Fax:_____

Information to be released (please mark the box)	☐ Medical record set (office visit notes, lab, radiology report, medication list, allergies, immunizations) ☐ Immunization record ☐ Provider Notes ☐ Laboratory reports ☐ Radiology ☐ Dental progress notes ☐ Dental X-rays ☐ Other: _____
Special Disclosure (The following information requires special consent by law)	**I specifically authorize release of the following information:** (***Initial each item you authorize to release/receive)*** (Initial here) _____ CCA/Psychosocial Assessment (Initial here) _____Treatment Plan (Initial here) _____ Psychological Evaluation (Initial here) _____Medication List (Initial here) _____ Psychiatry notes (Initial here)_____Other:_____
Expiration date	The authorization lasts for **one year** after the date you sign it unless you enter a different date here: _____/_____/_____
Purpose	☐ Coordination of care ☐ Legal* ☐ Disability/Insurance ☐ Other: _____ ☐ Personal Use*: *Fees may be charged in accordance with Federal Rule 45 CFR 164.524
Your Rights	• The Authorization form is voluntary, and you may refuse to sign it. You may also cross out any words on this form that you do not agree with. • MedNorth will not restrict your treatment if you chose not to sign this authorization. • A photocopy/fax of this authorization will be treated in the same way as an original. • MedNorth records may include records that it received from other organizations. If these records have been used by MedNorth and filed in the record MedNorth maintains about you, these records may be released with your MedNorth records. • MedNorth cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released By signing this authorization, you release MedNorth from any and all liability resulting from a redisclosure of the recipient. • Records covered under Federal Rule 42 CFR part 2 and the HIPAA Act of 1996, 45 CFR 160 & 164 and state confidentiality law governing substance abuse services (GS 112C) cannot be disclosed or redisclosed without your written consent unless otherwise provided for in the regulations. You can revoke your authorization by completing section below at any time. • Substance abuse information may be shared without consent to the extent necessary to meet a bona fide medical emergency. • Redisclosure of substance abuse information without consent is restricted to any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE

_____ _____ _____

Signature of Patient/Patients Guardian **Printed Name** **Date**

MedNorth – Health Information Management
925 North 4th Street Wilmington, NC 28401
Phone: 910-343-0270 Fax: 910-251-1540 Dental fax: 910-202-8665

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Note: If the patient is a minor, lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient: ☐Healthcare Agent/POA ☐ Parent/Guardian ☐ Executor/Administrator ☐ Social services

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization.

_____ _____ _____

Signature of Minor Printed Name Date

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of
(Name of Client) _____ signed by (Enter Name of Person Who Signed Authorization) _____on (Enter Date of Signature) _____ be rescinded, effective _____. I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Patient_____Date_____

Signature of Witness _____Date_____

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