## Authorization to Disclose Protected Health or Billing Information

**Patient Information: I give permission to release the health information of:** **(One patient per form)**

Patient Name: ______________________ Date of birth: ____________

Street Address: ______________________ Last 4 numbers of SSN: ____________

City, State, Zip: ______________________ Telephone: ( )

Email address: ______________________

*Although Novant Health will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.*

**Release Information From:**

(list applicable Facility(s) and/or Practice(s))

**Release Information To:**

(Name of facility, person, company) (Relationship)

(Street address or PO Box, City, State, Zip code)

(Phone number) (Fax number)

**Purpose of Release (check reason):** ☐ Request of individual / personal ☐ Insurance ☐ Disability ☐ Workers Compensation ☐ Legal purpose including discussions & proceedings ☐ Other:______________________

**Must fill in dates of treatment for records to be released:** Treatment dates FROM:______________ TO:______________

**Hospital (check all that may apply):**

☐ **Hospital Abstract**

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Diagnostic Test Results
- ☐ Medications
- ☐ Allergies
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Emergency Record
- ☐ Cardiac Reports/EKG
- ☐ Laboratory Reports
- ☐ Radiology/X-Ray Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Other:______________

☐ Entire Record (not including psychotherapy notes)

**Office/Clinic (check all that may apply):**

☐ **Office / Clinic Abstract**

- ☐ Office Visits
- ☐ Physical Exam
- ☐ Consultation Reports
- ☐ Diagnostic Test Results

☐ Laboratory Reports
☐ Radiology Reports
☐ Medications
☐ Billing Information
☐ Other:______________________

☐ Entire Record (not including psychotherapy notes)

**Format (only select one):**

☐ Paper copy (charges may apply) ☐ Electronic copy
☐ CD (charges may apply) ☐ Other: ______________________

**Delivery Method:**

☐ Reg. US Mail ☐ Pick-up ☐ Email ☐ Fax
☐ Other:______________________

**I understand that:**

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

**This permission expires 90 days after the date of my signature unless another date or event is written here:______________**

**Signature:** ______________________ **Print name:** ______________ **Date/Time:** ______________

**Note: If the patient 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 (Written Proof May be Requested):**

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Parent ☐ Next of Kin
☐ Other: ______________________

**Signature of minor:** ______________________ **Print name:** ______________ **Date/Time:** ______________

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

☐ Interpreter Accepted ______________________________________ ☐ Interpreter Refused

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

***For office use only***

Date of release: ______________________via ☐ mail ☐ fax ☐ other______________ ☐ ID verified ☐ DL/Other ID______________

NH Employee Name & Title: ______________________ NH Employee User ID: ______________________ Date/Time:______________

NOVANT HEALTH

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900010 R 7/03/2015

Patient Name: ______________________

DOB:______________

Or label

Name / MR# / Label