Hope Medical Clinic P.A

3609 Cape Center Drive, Fayetteville, NC 28304
Phone: 910.500.0909 Fax : 910.920.4224

Authorization to Release Protected Health Information

Patient Name: _____ Birth Date: ____/____/_____
Address: _____ SSN: _____/_____/_____

☐ I hereby consent to and authorize Hope Medical Clinic, PA to *Release* To

☐ I hereby consent to and authorize Hope Medical Clinic, PA to *Receive* From

_____
Name of Facility/Individual to Receive/Release Information Phone/Fax Number

_____
Address

_____
City State Zip Code

Protected Health Information concerning the history, treatment, examination and/or hospitalization of the above patient, I understand that the specific type of PHI to be released / received includes:

☐ Discharge Summary ☐ History and Physical ☐ Emergency Department Record

☐ Operative/Procedure Reports ☐ Consultation Reports ☐ Labs, X-rays, EKGs, etc.

☐ Shot Record ☐ Other Problem: _____
Dates:-

☐ 2 years prior from last date seen ☐ Dates Other: _____

The purpose for releasing/receiving this information is: _____

Restriction: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the following:-

- I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS); or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- My healthcare and the payment for my healthcare will not be affected by signing this form.
- Hope Medical Clinic, PA may condition the provision of healthcare that is solely for the purpose of creating PHI for disclosure to a third party, upon signing an authorization for disclosure of the PHI to such third party.
- Hope Medical Clinic, PA may condition the provision of research related treatment on provision of an authorization for the use or disclosure of PHI for such research.
- If the requester or receiver is not a health plan or healthcare provider, the release information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I may revoke this authorization at any time in writing. Revocation of this release will not have any effect on any actions previously taken. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Hope Medical Clinic, PA will provide me with a copy of this signed authorization.

Signature of Patient or Legal Representative Date

Relationship to Patient

Signature of Witness Date

This consent will automatically expire 90 days from date of signature, unless another date is specified below.

*Authorization not valid beyond: _____ (Date cannot exceed one year from date of signature.)

☐ Mail ☐ Pickup ☐ Fax Phone number/Contact for Questions: _____

PLEASE NOTE: ALL RECORDS OVER 20 PAGES SHOULD BE SENT BY MAIL ONLY