CAROLINAEAST MEDICAL CENTER

NEW BERN, N.C.

AUTHORIZATION FOR RELEASE / DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM CMC

I hereby authorize the release or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. By signing this Authorization, I understand that I am giving my authorization to CarolinaEast Medical Center ("CMC") to disclose my protected health information ("PHI") as specified in this Authorization. I further understand that if the person or organization I authorize to receive the information is not a health care provider or health plan, the released information may no longer be protected by federal or state privacy regulations.

I authorize CarolinaEast Medical Center to disclose the following information from the medical records of:

Patient Name: ______________________________ Date of Birth: ________________

Address: ____

Telephone: ________________ Patient Medical Record Number: ________________

Covering the period(s) of health care:

From ____________ to ____________; From ____________ to ____________

Information to be disclosed:

- ☐ Complete health record(s)*, including all images (X-rays, CT Scan, MRI, Ultrasound, Nuclear Medicine, Mammograms, photographs, etc.)
- ☐ Complete health record(s)*, excluding all images
- ☐ Include records from providers other than CMC (contained in CMC's records)
- ☐ Do not include records from providers other than CMC (contained in CMC's records)

* Includes any communicable disease, drug and alcohol records and mental health records, except Psychotherapy Notes, for which a separate authorization must be signed.

OR

Select from the following (check as many as apply):

- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Consultation Reports
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ X-ray/Imaging Reports
- ☐ Billing Records
- ☐ Mental health care or services (does not include Psychotherapy Notes for which a separate authorization must be signed)
- ☐ Photographs, videotapes, X-rays, CT Scan, MRI, Ultrasound, Nuclear Medicine, Mammograms, digital or other images
- ☐ Other (please specify) ____

____

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The purpose of the disclosure is:

☐ Claim or suit for personal injury. CMC reserves its rights to a provider lien under N.C.G.S. § 44-49.

☐ Other. Please Specify ____

____

This information is to be disclosed to the following individual or entity:

Name: _____________________________ Relationship: ____________________

Address: ____

Telephone: ________________________ Facsimile: _________________________

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, that this authorization will expire within six months of signing or on the happening of __________________ if sooner.

Initials: _________

b. I understand that I may revoke this authorization at any time by notifying CMC in writing, but if I do it will not have any effect on any actions CMC took before it received the revocation.

Initials: _________

c. I understand that CMC cannot make me sign this authorization as a condition to receive treatment from CMC except:

(i) when CMC provides me with research-related treatment in which I have agreed to participate; or

(ii) when I have asked CMC to provide me with health care solely for the purpose of creating protected health information for disclosure to someone else, such as my employer.

Initials: _________

CMC, its employees, officers, and physicians involved in my care are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

________________________________ ________________________________

Signature of Patient or Representative Date

________________________________ ________________________________

Print Name Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

____

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****