CAROLINAEAST PHYSICIANS

AUTHORIZATION FOR RELEASE / DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM CAROLINAEAST PHYSICIANS

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 Physicians, an entity that is part of CarolinaEast Health System, 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 Physicians to disclose the following information from medical records of:

Patient Name:________________________________Date of Birth: __________________

Address: ____

Telephone:__________________Patient Medical Record Number: __________________

Patient Provider Name(s):____

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 the practice (contained in the practice's records)
- ☐ Do not include records from providers other than the practice (contained in the practice'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) ____

____

CAROLINAEAST PHYSICIANS

AUTHORIZATION FOR RELEASE / DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM CAROLINAEAST PHYSICIANS Page 2 of 2

The purpose of the disclosure is:

☐ Claim or suit for personal injury. The practice 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 ___________________ .

Initials: _________

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

Initials: _________

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

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

(ii) when I have asked the practice 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: _________

The practice as part of CarolinaEast Physicians, an entity that is part of CarolinaEast Health System, and its and their respective employees, officers, and physicians who are or may be 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 ****

CAROLINAEAST
PHYSICIANS

CarolinaEast Physicians
2000 Neuse Blvd.
New Bern, NC 28561
Phone: 252.633.8111

CarolinaEast Physicians complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak any language other than English, language assistance services, free of charge, are available to you. Call 910-938-3099.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 910-938-3099.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 910-938-3099.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 910-938-3099.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 910-938-3099 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 910-938-3099.

252-752-5227 - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 910-938-3099.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 910-938-3099.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 910-938-3099.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 910-938-3099.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 910-938-3099.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 910-938-3099

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 910-938-3099 पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 910-938-3099.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 910-938-3099