INSTRUCTION SHEET

> These fields must have initials in them to release records related to these items

New Hanover Regional Medical Center
MEDICAL RECORDS/HEALTH INFORMATION MANAGEMENT
Post Office Box 9000, 2131 South 17th Street
Wilmington, NC 28402 - 9000
Telephone: (910) 343 - 7090
Fax: (910) 343 - 7186
Fax: (910) 342 - 3525

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*** Required Fields**

Section A:* **Must be completed for all authorizations**

PATIENT IDENTIFICATION: ______________________________
First Middle Maiden/Former Last

Account Number ____________________

Date of Birth ________________________ Social Security # XXX-XX-______

Phone # ____________________________ Medical Record # ____________________

SPECIFIC INFORMATION NEEDED: ****see information on back**

- ☐ Abstract**
- ☐ History and Physical
- ☐ Pathology Report
- ☐ Consults
- ☐ Discharge Summary
- ☐ HIV / AIDS (____ **initials***)
- ☐ Prenatal Records
- ☐ Clinic Notes
- ☐ Electrocardiogram
- ☐ Lab Report
- ☐ Radiology Report
- ☐ Financials
- ☐ Emergency Dept Records
- ☐ Operative Report
- ☐ Psych Records (____ **initials***)
- ☐ Photographs, videotapes, digital or other images
- ☐ Information regarding treatment of substance abuse (____ **initials***)
- ☐ Other (Please specify) ______________________________

PURPOSE:* Disclosure of this information is needed for...
☐ Continuity of Medical Care ☐ Insurance Processing ☐ Legal Proceedings
☐ Personal Use ☐ Other (Please specify) ____________________

AUTHORIZATION:* I authorize and request ______________________________ to release medical information to ______________________ concerning my treatment to cover the period from ______________ to ______________

> The name of facility/phy from where the records are coming from

> Receiver of records

> Dates of service- Not Event

Section B: **Must be completed only if a health plan or a health care provider has requested this authorization**
Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No_____

Section C:* **Must be completed for all authorizations**
I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials*** ________
I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I will be given a copy of this authorization form, after signing. **Initials*** ________

> Must have initials in both fields. 2nd Box states we will give yellow copy to patient

Section D:* **Must be completed for all authorizations**
I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
I understand that I may revoke this authorization at any time by notifying The Medical Records Department in writing and that this will automatically **expire on** _____/_____/_____* **(MM/DD/YY)** or 1 year from the date signed below, whichever is earlier. This hereby releases the sender from all legal responsibility or liability of the release of information described above from the records. I also understand that if I revoke my authorization it will not have any effect on any actions NHRMC took before it received the revocation. I understand that medical records, laboratory reports, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

> Must write date in field

Printed Name:* ______________________________
(Patient or Authorized Representative)

Date:* ______________________ **Signature:*** ______________________________
(Patient or Authorized Representative)*

Witness:* ______________________ ______________________________
(Relationship if other than Patient)*

> Witness to signature of patient or representative must sign and date form

> Must have patient/ representative signature. Must have appropriate paperwork from representative

Form of identification* ☐ Drivers License ☐ State issued ID ☐ Military ID ☐ Other ____________

> Must have Form of identification. Make copy and attach to Authorization. Mark what type of identification

PLEASE SEND THIS INFORMATION TO THE ATTENTION OF:	SENDERS INFORMATION (NHRMC STAFF ONLY)
	Fax to: ____________
	Number: ____________
	Address: ____________
	By Whom: ____________
	Date Sent: ____________

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
THIS FORM PART OF PERMANENT MEDICAL RECORD

> Please put in receiver's information Example: NHRMC - Dept/Name

> To be completed by NHRMC staff only. To be filled out when request is fulfilled. Please fill out all lines. Especially by whom: and date sent: