New Hanover Regional Medical Center

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

3 Hole 1/4 4 1/4 c-to-c

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 _____

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*** _____

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.

Printed Name:* _____
(Patient or Authorized Representative)

Date:* _____ **Signature:*** _____
(Patient or Authorized Representative)*

Witness:* _____
_____
(Relationship if other than Patient)*

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

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

0153

White - Medical Records Yellow - Patient and or Authorized Representative

DEFINITIONS REGARDING RELEASE OF INFORMATION

An abstract includes summary of typed reports as listed below. This is not an all inclusive listing.

- Discharge Summary
- History & Physical
- Consults
- Operative Reports
- Pathology Reports
- Laboratory Reports
- Radiology Reports
- Special Testing (ie: echocardiogram)
- EKG
- Emergency Dept. Physician Record

Authorized Representative: is a guardian, parent, or healthcare agent. Example: Legal Documents that support the release of medical information to an authorized representative are:

- Healthcare Power of Attorney
- Power of Attorney
- Marriage License
- Death Certificate
- Executor of estate documents

Financials may include but are not limited to:

- Billing Claims Information
- Itemized Statement

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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.
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