Authorization to Disclose Protected Health or Billing Information

Patient Name: _____

Nickname/Maiden/Alias: _____

Phone #: _____

Date of Birth: _____

Medical Record #: _____

Patient Address: _____

I give permission to:

Person, _____

Facility, _____

Practice, _____

or _____

Department _____

To share my health information with: _____

Address: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Medical Information Sources

☐ ***Only*** include information from the Novant Health Facility / Practice / Department given permission above.

☐ Include information from the Novant Health Facility/Practice/Department given permission above ***as well as*** the following Novant Health location/s *(Specify)*:

Treatment Dates *(Specify Date or Date Range)*:

Information To Be Shared *(Check All that Apply)*:

☐ Entire Medical Record	☐ Insurance	☐ Progress Notes	☐ Other *(Specify)*:
☐ Billing information	☐ Laboratory Report	☐ Radiology Report	
☐ Consultation	☐ Medication Records	☐ Radiology Images	
☐ Discharge Summary	☐ Nurses Notes	☐ Surgery Report	
☐ History & Physical	☐ Physician Dictation	☐ Test Results	

Important Notice: This is a full release, including drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:

Reason to Disclose Health Information:

☐ My (Patient) Request ☐ Treatment ☐ Disability ☐ Other *(Describe)*:

☐ Workers' Compensation ☐ Insurance ☐ Legal

How to Deliver Health Information: ☐ In Person ☐ Pick up ☐ Fax ☐ Mail ☐ Email *(Encrypted/Secure)*

1. By law, Novant Health ("Novant") cannot use or share my health information without my permission, except by ways listed in Novant's Notice of Privacy Practices.
2. I can cancel this permission at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel the sharing of information already given as a result of this permission.
3. I do not have to sign this form. Refusal will not change my ability to get treatment, payment for treatment, or benefits.
4. Once information is sent, it may not be protected by law. Someone may be able to share my information with others without my permission.
5. I have read, understand, and, upon my request, been given a copy of this form.
6. This is not for use for Marketing or Research.

Notice: A fee may be charged to make copies of the requested medical record.

My permission ends 90 days after the date I signed, unless a date or event is written here: _____

Patient or Patient Representative Signature	**Date**	**Witness Signature**	**Date**

Legal Authority to sign for patient: ☐ Healthcare agent ☐ Guardian ☐ Attorney in Fact ☐ Parent ☐ Next of Kin ☐ Administrator/Executor

If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.

Patient is: ☐ Minor ☐ Disabled ☐ Deceased ☐ Incompetent ☐ Incapacitated

If limited English proficient or hearing impaired, offer an interpreter at no additional cost. ☐ Interpreter Accepted ☐ Interpreter Refused

_____ (Name/number of person/services chosen/used)