

Authorization to Disclose Protected Health or Billing Information

Patient Information: I give permission to release the health information of:

(One patient per form)

Patient Name:
Street Address:
City, State, Zip:
Email address:

Date of birth:
Last 4 numbers of SSN:
Telephone: ()

Although Novant Health will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release Information From: (list applicable Facility(s) and/or Practice(s))
Release Information To: (Name of facility, person, company) (Relationship)
(Street address or PO Box, City, State, Zip code)
(Phone number)

Purpose of Release (check reason): Request of individual / personal Insurance Disability Workers Compensation
Legal purpose including discussions & proceedings Other:

Must fill in dates of treatment for records to be released: Treatment dates FROM: TO:

Hospital (check all that may apply):
Hospital Abstract
History & Physical Discharge Summary Operative Reports Consultation Reports Diagnostic Test Results Medications Allergies Physician Orders
Progress Notes Emergency Record Cardiac Reports/EKG Laboratory Reports Radiology/X-Ray Reports Pathology Reports Billing Information Other:
Entire Record (not including psychotherapy notes)

Office/Clinic (check all that may apply):
Office / Clinic Abstract
Office Visits Physical Exam Consultation Reports Diagnostic Test Results Laboratory Reports Radiology Reports Medications Billing Information Other:
Entire Record (not including psychotherapy notes)

Format (only select one):
Paper copy (charges may apply) Electronic copy
CD (charges may apply) Other:

Delivery Method:
Reg. US Mail Pick-up Email
Other:

- I understand that:
I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
A fee may be charged for providing the protected health information.
I have a right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless another date or event is written here:

Signature: Print name: Date/Time:

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

Healthcare Agent/POA Guardian Executor/Administrator/Attorney in Fact Parent Next of Kin
Other:

Signature of minor: Print name: Date/Time:

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter Accepted Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

For office use only

Date of release: via mail fax other ID verified DL/Other ID
NH Employee Name & Title: NH Employee User ID: Date/Time:



Patient Name:
DOB:
Or label
Name / MR# / Label