



VIDANT HEALTH

- Vidant Medical Center
- Vidant Chowan Hospital
- Vidant Medical Group
- Albemarle Hospital
- Other \_\_\_\_\_
- Vidant Beaufort Hospital
- Vidant Duplin Hospital
- Vidant Pungo Hospital
- Outer Banks Hospital
- Vidant Bertie Hospital
- Vidant Edgecombe Hospital
- Vidant Roanoke-Chowan Hospital
- SurgiCenter

Authorization/Consent  
for Release of Protected  
Health Information

**SECTION A: The person for whom this authorization is being requested. Please complete the following:**

Name of patient _____	Prior name(s), if any _____
Street Address _____	Social Security Number (Last 4 digits only) _____
City _____	Date of Birth _____
State _____ Zip Code _____	Area Code and Telephone Number _____

**SECTION B: Who will provide this information? (Vidant Health Entity, Address & Phone)**

**SECTION C: Who will receive this information?**

Name/Dept. \_\_\_\_\_

Address \_\_\_\_\_

**SECTION D: How will information be sent/received?**

Mail to address listed above       Pick Up

Electronic (Email)\*: \_\_\_\_\_

*\*Note: Instructions for electronic access will arrive by email within 3 business days.*

**SECTION E: Describe the reason for the request.**

Attorney/Legal       Continued Care

Personal Use       Insurance

Other: \_\_\_\_\_

**SECTION F: Describe the specific Protected Health Information to be used or disclosed, including date(s):**

Psychotherapy Notes for date(s) \_\_\_\_\_

IF THIS BOX IS CHECKED, A SEPARATE AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO AUTHORIZE RELEASE OF ANY OTHER TYPE OF PROTECTED HEALTH INFORMATION (PHI).

<input type="checkbox"/> Entire Treatment Record	Date(s) _____
<input type="checkbox"/> Billing Statements	Date(s) _____
<input type="checkbox"/> Laboratory Reports	Date(s) _____
<input type="checkbox"/> Diagnostic Images (X-ray, etc.)	Date(s) _____
<input type="checkbox"/> Other (Describe) _____	Date(s) _____

**SECTION G: By signing below I indicate my understanding that:**

- ↓ This authorization is voluntary. Treatment or payment will not be affected if I do not sign this form, except as provided by law.
- ↓ I understand information released may be related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. I also understand that the information may be re-disclosed by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.
- ↓ I may revoke this authorization at any time by notifying in writing the entity listed in Section B, but if I do revoke this authorization it won't have any effect on any actions the entity may have taken before it received the revocation.

**SECTION H: Expiration and Revocation**

This authorization will expire (check one):  On (enter date): \_\_\_\_\_ Or  (Enter event or date): \_\_\_\_\_

**SECTION I: Signature**

I hereby authorize the use or disclosure of the Protected Health Information as described above.

Signature of patient or patient's Personal Representative \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Signature of individual releasing requested PHI \_\_\_\_\_ Print Name of individual releasing PHI \_\_\_\_\_

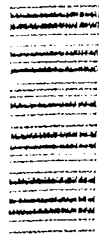
**SECTION J: If Section I is signed by a Personal Representative, please complete the information below:**

Print Representative's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature of Person Verifying Representative's Authority \_\_\_\_\_

Print Name of Person Verifying Representative's Authority \_\_\_\_\_

Witness Signature	Witness PRINTED Name	Date/Time
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