AUTHORIZATION FOR RELEASE OF INFORMATION FOR CONTINUING PATIENT CARE

USE THIS AS A COVER SHEET WHEN FAXING

I, ______________________________ DOB: ______________, authorize my physician and or their administrative and clinical staff to:

Receive from:

____
Name of Facility/Individual

____
Address

____
Fax Number Phone Number

Release to:

____
Name of Facility/Individual

____
Address

____
Fax Number Phone Number

Information concerning the history, treatment or examination of the above-named patient for the purpose of continuing health care. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive/release my protected health information is not a health plan or health care provider, my health information may no longer be protected by federal privacy regulations once it is disclosed.

My protected health information that may be disclosed includes dates ______________ to ______________.
☐ Entire Medical Record ☐ Treatment Record ☐ Diagnostic Tests__________ ☐ Other__________

I give special authorization for the following information to be used or disclosed:
☐ Psychological/Psychiatric/Mental Health Information (this includes Psychotherapy notes)
☐ HIV/AIDS Information ☐ Substance Abuse Information

This authorization shall be effective until ______________, at which time this authorization will expire.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to NorthEast Digestive Health's Center (NDHC) Privacy Officer at 1070 Vinehaven Drive, NE Concord, N.C. 28025. I understand that, even if I revoke my authorization, it will not be effective to the extent NDHC has relied on it to use or disclose my protected health information, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that NDHC Notice of Privacy Practices discusses my right to revoke and my other rights.

I understand that NDHC will not condition my treatment on whether I sign this authorization except: (1) if my treatment is related to research, or (2) the health care services are being provided to me solely for the purpose of disclosing my health information to a third party, such as a referring physician or a return to work authorization.

I have read (or had read to me) the above authorization and I understand my rights with regard to my protected health information. I have been provided with a copy of the authorization.

Northeast Digestive Health Center is hereby released from any liability that may arise from the release of this information.

____
Signature of Patient or Legally Responsible Person

____
Date

____
Print Name of Patient or Legally Responsible Person

____
Relationship to Patient

____
Address

____
Social Security Number of Patient

____
Witness

OFFICE USE ONLY

DATE COMPLETED:______________________ Completed by:______________________