

**AUTHORIZATION for USE or DISCLOSURE
of PROTECTED HEALTH INFORMATION**

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(patient name & date of birth)

To be Released From/By: _____
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: _____
(Name of Entity, Person(s) or class of persons authorized to receive the information)

(Address of authorized recipient of information)

(City/State/Zip)

Phone Number

Fax Number

Description of information that may be used/disclosed: (The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)

Specific records:

- | | |
|---|--|
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Radiology result |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Cardiac Catheterization |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology report |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Lab result |
| <input type="checkbox"/> Office/Clinic Note | <input type="checkbox"/> Other specific (please list): _____ |
| | <input type="checkbox"/> Entire visit (provider notes, results, flowsheets/nursing notes, scanned documents, etc.) |

Must provide the **treatment/visit date(s)**: most recent or specific date range _____ to _____

Please provide the **treatment location** (specific hospital, or physician practice location, department): _____

The information will be used/disclosed for the following **purpose**:

- At the request of the individual treatment insurance legal changing doctors Other: _____

Requested format: Electronic Copy Paper copy CD Other _____ (if not specified, records will be provided in paper form)

Delivery method: US mail unless otherwise requested as: pickup MyChart (if available, appropriate) Other: _____

- I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.
- I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

Signature of Patient or Personal Representative (if applicable)

Date/Time

Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient
(written proof may be required)

This release is limited to the Facility/Practice or Department you specified above.

To obtain information from another Facility/Practice or Department individual authorizations will be needed.

Please contact the specific department or WFBH HIM Department at (336) 716-3230 with questions.

