



Request for/Authorization to Use & Disclose Protected Health Information (PHI)

I hereby authorize Black River Health Services, Inc., dba Black River Health Center, Black River Family Practice, or Maple Hill Medical Center, to request/release a copy or copies of the specific health and medical information described below regarding:

Name of Patient (First, MI, Last)

Date of Birth

BRHS Chart #

From/To: **Black River Family Practice**
301 S. Campbell Street
Burgaw, NC 28425
Ph: (910) 259-5721
Fax: (910) 259-8002

To/From: _____

Period of healthcare covered:

- All Records
 Records from (date) _____ to (date) _____

Information requested or information to be used/disclosed:

- Complete health record(s) Office Visit Notes Consultation Reports
 Laboratory results Diagnostic Reports Procedure reports
 Radiology reports General Correspondence
Other (please specify) _____

I give special permission to release any information regarding:

- Mental health or Psychiatric Information

Purpose of Disclosure: Continuation of Medical care
 Other (Please specify): _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
You may inspect a copy of the protected health information to be used or disclosed;
You may refuse to sign this Authorization; and
We must provide you with a copy of the signed authorization.

I understand and acknowledge that this authorization may include consent for release of alcohol/drug abuse, mental health, pregnancy, sexually transmitted diseases, or HIV/AIDS information.

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient/Patient Representative Signature

Date

Patient Representative Authority/Relationship

Initials of Sender

Witness Signature