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: **Maple Hill Medical Center**
4811 NC Hwy 50
Maple Hill, NC 28454
Ph: (910) 259-6444
Fax: (910) 259-6659

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)
☐ Laboratory results
☐ Radiology reports
☐ Office Visit Notes
☐ Diagnostic Reports
☐ General Correspondence
☐ Consultation Reports
☐ Procedure reports

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