Piedmont HealthCare ~ P.O. Box 1845 ~ Statesville, NC 28687
Phone: (704) 978-3546 Fax: (704) 696-2570
*** FAX is for requests only. DO NOT FAX OUTSIDE RECORDS**

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ Print Patient Name	_____ Date of Birth
_____ Street Address / P.O. Box	_____ Phone (home)
_____ City / State / Zip Code	_____ Phone (work)

1.) I hereby authorize the use and/or disclosure of my protected health information as described below.
Medical Record personnel and/or the Privacy Officer of Piedmont HealthCare are hereby authorized to make the use or disclosure of the information as set forth below.

SEND MEDICAL RECORDS TO:	MEDICAL RECORDS FROM:
_____ Name (facility/physician/person)	_____ Name (facility/physician/person)
_____ Complete Address	_____ Complete Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone Number & Fax Number	_____ Phone Number & Fax Number

The specific description of information that may be used/disclosed:

Covering the dates of treatment from _____ ***(date)*** **to** _____***(date).***

☐ Immunization Records ☐ Office Visit Notes ☐ X-Ray Reports
☐ Entire Record ☐ Lab Reports / Pathology Reports ☐ Other _____

I understand that the information released may include information related to AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), infection, psychiatric care and/or psychological assessment, or treatment for alcohol and/or drug abuse, unless otherwise specified here: ☐ **Do not release**

The information will be used/disclosed for the following purpose(s):

☐ Patient Request ☐ Transferring Physicians/Moving ☐ Attorney
☐ Insurance ☐ Referral from PHC Physician ☐ Other _____

2.) I understand that (i) the information disclosed to a third party in accordance with the terms of this authorization may be re-disclosed, and (ii) once disclosed to a third party, my health information may no longer be protected by federal privacy regulations.

3.) I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Piedmont HealthCare, except that:

a. if I refuse to sign this authorization, and this authorization is for research purposes, then Piedmont HealthCare may refuse to allow me to participate in the research, and

b. if the purpose of this authorization is to share pre-employment or employment screening tests with my prospective or current employer and I refuse to sign this authorization to allow my prospective or current employer to receive the results of such testing, then Piedmont HealthCare may refuse to provide such testing.

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4.) I have been provided with a copy of Piedmont HealthCare's Notice of Privacy Practices.
I understand that I may revoke this authorization at any time in writing to the PHC Privacy Officer (see Notice of Privacy Practices) or to the office where this authorization was submitted except to the extent that the information has already been released.

5.) This authorization expires on _____ *(insert date)*.If I fail to specify an expiration date, this authorization will expire automatically ninety (90) days from the date of signature.

I have read and understand the information in this authorization. I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

If personal representative, please check legal authority to act on patients behalf, and include legal documents to confirm the legitimacy of the patient's representative.

☐ Parent of Minor ☐ Guardian ☐ Power of Attorney ☐ Executor of Estate ☐ Other_____

******** Please allow 5-10 working days for medical records to be processed********

NOTE: THERE MAY BE A CHARGE FOR COPYING YOUR RECORDS—APPLIED IN ACCORDANCE WITH NORTH CAROLINA LAW.

❖ The charge for this service is as follows, according to North Carolina Law:
(Plus shipping and handling charges)
$10.00/pgs 1-13 $.75/pgs13-25 $.50/pgs26-100 $.25/pgs 101 and over

Thank you,

PHC Health Information Department