Piedmont HealthCare ~ P.O. Box 1845 ~ Statesville, NC 28687
Phone: (704) 978-3546 Fax: (704) 696-2570
*Above FAX # is for Requests for Records Only. PLEASE DO NOT FAX OUTSIDE RECORDS TO ABOVE # *

## 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.**

****Please Fill Out the Below Section Completely – If Not Filled Out Completely Request Could Be Returned****

| (Indicate Where records need to be sent) | (Indicate which Doctor you need records From) |
|---|---|
| **Send Medical Records TO:** | **Medical Records FROM:** |
| Emily Nabors, MD. | |
| Name (facility/physician/person) | Name (facility/physician/person) |
| 142 Professional Park Dr. #300 | |
| Complete Address | Complete Address |
| Mooresville NC 28117 | |
| City, State, Zip Code | City, State, Zip Code |
| 704-696-2083 704-660-0215 | |
| Phone Number & Fax Number | Phone Number & Fax Number |

*** Please Indicate the Date Range Needed Covering Dates of Treatment:**

**From:** _____ *(date)* **To:** _____ *(date).*

*** Please Indicate the Type of Information Needed:**

☐ Office Visit Notes ☐ X-Ray/MRI/CT Reports
☐ Immunization Records ☐ Lab Reports/Pathology Reports ☐ Other _____

- OR -

☐ Entire Record (This Includes: All Office Notes/Labs/Imaging Reports/Immunizations)

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**

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

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

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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.

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**

**<u>If you are the patient's personal representative, please check legal authority to act on patient's behalf below.</u>**

****<u>Also, be sure to include legal documents to confirm your legitimacy as the patient's representative.</u>****

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

## <u>**** Please allow 5-7 working days for medical records to be processed****</u>
## <u>CENTRAL MEDICAL RECORDS DOES NOT PROCESS SAME DAY REQUESTS</u>

**NOTE: THERE MAY BE A CHARGE FOR COPYING YOUR RECORDS—APPLIED IN ACCORDANCE WITH NORTH CAROLINA LAW and the HITECH ACT:**

- The charge for this service is as follows, according to North Carolina Law and the HITECH Act:

**$10.00/pgs 1-13 Per Page Amount $.75/pgs13-25 $.50/pgs26-100 $.25/pgs 101 and over**
**PER CD:** Standard charge of **$15.00**
**ATTORNEY REQUESTS:** Standard charge of **$25.00**

**Thank you,**
**PHC Central Medical Record Department**