NeighborHealth

Authorization to Release Health Information

4201 Lake Boone Trail Suite 005
Raleigh, NC 27607
P) 984-222-8000 F) 984-222-8001

Patient Information:

Name: _____

Birthdate: _____

Social Security: _____

Phone: _____

I authorize NeighborHealth Health to release information to:

Person / Institution: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Information to be Released

- ❍ Immunization/shot records
- ❍ School physical form
- ❍ Laboratory reports
- ❍ Billing records
- ❍ Complete medical record
- ❍ Prenatal records
- ❍ Radiology reports
- ❍ Other _____

I specifically **prohibit** the release of the following sensitive health information. I understand that for any of the following boxes that are not checked, the health information released to the named recipient may include diagnosis, evaluation and/or treatment information for the following:

- ❍ HIV or AIDS testing information or results
- ❍ Alcohol and/or substance abuse
- ❍ Behavioral health

Dates of Service Requested

- ❍ Most Recent
- ❍ From _____ to _____
- ❍ All

Reason for Release

- ❍ Patient request
- ❍ Continuity of Care/Other provider
- ❍ Other (specify) _____

Delivery Requested

- ❍ Electronic by secure message (e-mail)
  email address: _____
- ❍ Paper by mail
- ❍ Paper by fax

I understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the Privacy Officer at this site of care, except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released. I understand that this authorization is voluntary and I may refuse to sign this authorization. The above named person/institution will not refuse to treat me based on whether I allow my health information to be used and disclosed by others. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. This authorization shall remain valid unless revoked but will expire 90 days from the date of my signature or as otherwise specified by the date, event or condition(s) as follows: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian or Representative (Required if patient is not legally authorized to sign authorization) Relationship to Patient

_____ _____
Witness Signature Relationship to Patient

NeighborHealth OFFICE USE ONLY

Charge: _____ ❍ None (Sending to Medical Provider) ❍ .75 per pg.-max $20 (all others)

Payment Received ❍ Yes ❍ No (requested to be billed)

PHI released by (staff name): _____ Date: _____ ❍ Mail ❍ Fax