



2605 Blue Ridge Road, Suite 225  
 Raleigh, NC 27607  
 P) 984-222-8000 F) 984-222-8001

## Authorization to Release Health Information

### Patient Information:

Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_  
 Social Security: \_\_\_\_\_  
 Phone: \_\_\_\_\_

### I authorize NeighborHealth 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)   
  Paper by mail  
 email address: \_\_\_\_\_   
  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: _____	<input type="radio"/> None (Sending to Medical Provider) <input type="radio"/> .75 per pg.-max \$20 (all others)
Payment Received <input type="radio"/> Yes <input type="radio"/> No (requested to be billed)	
PHI released by (staff name): _____	Date: _____ <input type="radio"/> Mail <input type="radio"/> Fax