Medical Record #:_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Boice-Willis Clinic, PA
Fax: 252-937-2903

Patient Name: _____ Date of Birth: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I request that my health information be disclosed: *Please check appropriate box*

☐ To ☐ From: Boice-Willis Clinic PO Box 7200 Rocky Mount NC 27804 ATTN: _____

☐ To ☐ From: Facility/Office/Company/Person: _____
Address: _____ City: _____ State: _____ Zip Code: _____

These records will be used/disclosed for the purpose of: _____

I request that the medical records be: *Please check appropriate box.*

- ☐ Mailed directly to the facility/office/company/person specified above.
- ☐ Faxed to the following number. Fax Number: _____
- ☐ Email my protected health information. Email: _____

☐ I authorize Boice-Willis to give **verbal information only** regarding my treatment to the above person/s.

Date(s) of records to be released from: _____ to: _____ Provider: _____

The information to be disclosed to the above facility/office/company/person shall include: *Please check appropriate box(es).*

- ☐ Consultation
- ☐ Pathology Report
- ☐ Laboratory Reports
- ☐ Entire Medical Record
- ☐ Billing Record
- ☐ Operative Report
- ☐ Urgent Care Records
- ☐ Radiology Reports
- ☐ Summary
- ☐ Other (Specify): _____

I understand that by checking any boxes below I have given permission to give out confidential information related to drug and alcohol treatment records that are protected by federal law (42 CFR, Part 2); or HIV; or Mental Health. **I understand that I am not required to authorize the release of this information**. If these boxes are not checked, this information **will not** be released.

- ☐ Diagnosis and/or treatment relating to drug or alcohol abuse.
- ☐ Diagnosis and/or treatment relating to mental health conditions.
- ☐ Diagnosis and/or treatment relating to HIV testing, infection or diagnosis and/or treatment for AIDS.

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire 90 days from the date of my signature unless earlier revoked.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. **I understand that a fee may be charged.**

Boice-Willis Clinic, PA, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Legal Guardian /Personal Representative Signature **Date**