1202 Medical Center Dr.
Attn: Medical Records
Wilmington, NC 28401
Phone: 910-341-3308
Fax Requests to: 910-341-3419
Fax Records to: 910-341-1900

# Authorization for Use, Disclosure, and/or Request of Protected Health Information

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

**Specific information being requested:**

- ☐ All Pediatric records
- ☐ History/Office Notes
- ☐ Laboratory Test results
- ☐ Pap Smears
- ☐ Mammograms
- ☐ Immunizations
- ☐ Colonoscopy and/or EGD reports including associated Pathology reports
- ☐ Radiology reports (includes Bone Density, CT/CTA, MRI/MRA, Vascular, etc.)
- ☐ Cardiology Studies
- ☐ Other: (Please be as specific as we will only be able to provide the specific information you list)

_____

**Time Frame of records to be released:** (examples: 1 year, 2016 – current, or last 3 visits)

_____

**Unless initialed the following information will NOT be released or disclosed:**

_____ HIV/AIDS/Communicable Disease Status

_____ Alcohol and/or Drug Abuse or Treatment

_____ Mental Health Status or Treatment

**Entities Authorized to Use, Disclose, or Receive:** If persons or organizations authorized below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

| **Records Requested FROM:** | **Records Being Sent TO:** |
|---|---|
| Where are the records coming from? | Where are the records being sent? |
| Name of Provider or Organization: | Name of Provider or Organization: |
| _____ | _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Phone: _____ | Phone: _____ |
| Fax: _____ | Fax: _____ |

1202 Medical Center Dr.
Attn: Medical Records
Wilmington, NC 28401
Phone: 910-341-3308
Fax Requests to: 910-341-3419
Fax Records to: 910-341-1900

Patient Name:_____

Date of Birth:_____

**Preference for receipt of records:**

- ☐ Regular Mail
- ☐ Fax: _____
- ☐ Electronic Copy (disk)

**The purpose of the Use, Disclosure, and/or Request:** Fees may apply based on form of and reason for release of information.

- ☐ Changing Provider/Continuation of Care
- ☐ Insurance
- ☐ Attorney
- ☐ Personal Use
- ☐ Other: _____

**This Authorization will expire: (choose one)**

- ☐ 2 years after death of patient
- ☐ Upon written revocation
- ☐ Future Date: _____
- ☐ On the occurrence of the following event: _____

**By signing below, I understand:**

- I authorize the use and/or disclosure of my protected health information as described in this document.
- I may revoke this authorization at any time by providing written notice of my revocation. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before notice of revocation of authorization was received.
- I may refuse to sign this authorization and the request will be considered null and void.
- Wilmington Health may not condition my treatment on my refusal to sign this authorization.

Signature: _____

Date: _____ Last 4 digits of patient's social security number: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Witness: _____ Date: _____

If you have concerns about your privacy rights, please contact Wilmington Health Privacy Officer:
Phone: 910-796-7701 Fax: 910-772-1307 Address: 1202 Medical Center Dr. Wilmington, NC 28401
Email: privacyofficer@wilmingtonhealth.com