REQUEST # _____ FIN # _____

Rex Healthcare
4420 Lake Boone Trail
Health Information Management
Raleigh, North Carolina 27607
919-784-3158; Fax 919-784-3343

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize:		Rex Healthcare	OR		Other facility:

To use or disclose to:

Name of Person or Facility:		
Address, City, State, Zip:		
Phone:	Fax:	Email:

The protected health information of:

Patient Name:	Date of Birth:	Mother's Maiden Name:
Address:	City, State, Zip	
Phone:	Medical Record #	

Dates of Service: _____
Be as specific as possible

Information to be disclosed (please check (√) information requested)**:**

	Facesheet		Pathology Reports		MAR
	Discharge Summary		Progress Notes		Laboratory reports
	History and Physical		Physician Orders		Urgent Care Center Notes
	Consultations		Emergency Dept.		All Medical Records
	Operative / Procedure notes		Nursing Notes		Patient Billing records
	Pictures		Radiology Reports		Radiology - Film / CD
Other (describe)					

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.

The purpose of the use or disclosure is (please check (√) appropriate box)**:**

	Attorney/Legal		Continued Patient Care		Social Services / Disability
	Personal Use		Insurance		Other:

* R E Q 1 2 3 4 5 *

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FIN# _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that:

- I may revoke this Authorization at any time.
- The revocation will not apply to information that has already been released in response to this Authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.

I understand that:

- If I revoke this Authorization, I must do so in writing.
- The procedure for revoking this Authorization is to present my written revocation to the Health Information Management Department.

I also understand that:

- I may refuse to sign this Authorization.
- Rex Healthcare will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for copying the protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this Authorization form.

_____ _____
Signature of Patient Date

- OR -

_____ _____
Signature of Authorized Representative Date

_____ _____
Witness Date

Please explain the Representative's authority to act on behalf of the patient: _____
_____

OFFICE USE ONLY	
Date Completed: _____ Total Pages: _____ Completed By: _____ Sent via: Mail Courier Certified Mail Fax Pick-up Fax Number: _____ ☐ Fax # Verified ☐ I.D. Checked ☐ CD ☐ Paper CD Verification #1: _____ Date: _____ CD Verification #2: _____ Date: _____ CD Verification #3: _____ Date: _____	ADDITIONAL NOTES: