_____

Last Name **First Name** **MI**

Patient SS#: _____

Date of Birth: ____/____/____

NC Department of Health and Human Services
Public Health Nursing and Professional Development

PATIENT AUTHORIZATION
to Permit Use and Disclosure of
Health Information

I am either the patient named above or the patient's legally authorized representative.

By signing this form, I authorize _____

[1] *Person or class of persons authorized to use or disclose the information*

to use or disclose to _____

[2] *Person or class of persons to whom use or disclosure would be made*

the following protected health information *(identify the information in a specific and meaningful fashion)*:

_____

_____

The purpose of the use or disclosure is **[3]** *(describe each purpose of the requested use or disclosure)*:

_____

_____

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in

_____ 's

[4] *Name of covered entity*

Notice of Privacy Practices, a copy of which has been provided to me.

I understand that I may refuse to sign this authorization. I also understand that

_____

[4] *Name of covered entity*

cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization. **[5]**

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon _____

[6] *Date or event that relates to the patient or the purpose of the use or disclosure*

_____

_____ _____

*Signature of patient **OR** authorized representative* *Date*

_____

Please print name of patient or authorized representative who signed above

[7] *Please explain representative's authority to act on behalf of the patient:* _____

_____

_____

_____