Information to be used and/or disclosed and to whom

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below in this section. I understand that this authorization is voluntary. NO individual has coerced me into signing this authorization, and I am providing this authorization under my own free will. I understand that once this information is received by the authorized organization or person, then it may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws. **This authorization will expire on** _____ **.**

Select one of the following: ☐ GHS to provide copies TO: _____

_____

☐ GHS to obtain copies from: _____

Select one box in all sections:

Reason for request: ☐ Continued care ☐ Insurance ☐ Attorney ☐ Personal use ☐ Other_____

☐ ENTIRE RECORD ☐ Summary Information (Discharge Summary, Operative Notes/Procedure Notes, Radiology, Pathology, Laboratory, EKG, ED Notes, Clinic Visits, Consults)	☐ History & Physical ☐ Radiology Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Operative Report	☐ ED Record ☐ Discharge Summary ☐ Immunization Records ☐ PT/OT Notes	☐ Discharge Instructions ☐ Clinic Notes (Ambulatory Progress Notes) ☐ Other (Specify)

Treatment Date(s):

☐ Treatment dates from _____ to _____ (Please be specific) OR ☐ ALL Treatment Dates

Information to be Released:

☐ I would like to review on site in the Health Information Management Dept, the protected health information for the above dates.

☐ I would like copies of specific reports for the treatment dates listed above (check reports above) _____

☐ Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date. (May require physician approval.)

☐ Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse.

I Understand That:

- The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
- Without my express revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.

Right to Revoke

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use and/or disclosure have taken action in reliance on this authorization or, if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Signature

By signing below I acknowledge and affirm the statements in this authorization form.

☐ I have requested this information to be provided by GHS in an electronic format. I understand I am responsible for securing this data to prevent unauthorized access.

Signature of Patient or Patient's Representative:

Printed Name of Patient or Patient's Representative: **Date:**

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Executor of Estate ☐ Power of Attorney ☐ Other_____

Reason Patient unable to sign: _____

Witness Signature: **Date:**

Granville HEALTH SYSTEM
Quality Care...Close To Home
Granville Medical Center
P.O. Box 947
1010 College St • Oxford, NC 27565-0947

AUTH FORM

Authorization for Use and/or Disclosure of Information

First Name: _____

Last Name: _____

Date of Birth: _____