CUMBERLAND COUNTY
NORTH CAROLINA

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

DEPARTMENT OF PUBLIC HEALTH
1235 Ramsey Street
Fayetteville, NC 28301

I authorize the Cumberland County Department of Public Health to release the noted protected health information from the medical records of the patient listed below:

Patient's Name: _____ Date of Birth: ____/____/___ SS# _____-_____-_____
Last Name First Name MI

To the agency or individual indicated below:

Facility/Person _____ Telephone Number: _____

Street Address _____ Fax Number: _____

City/Zip Code: _____ Attn: _____

To include the following information:

- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Radiology Report
- ☐ History & Physical
- ☐ Family Planning Records
- ☐ Communicable Disease (STD, HIV, TB records)
- ☐ Laboratory Reports (Please specify) _____
- ☐ Information contained in the patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date.
- ☐ Other: _____

For the Purpose of:

☐ Sharing with other Health Care Provider ☐ Continuity of Care ☐ Insurance Processing
☐ Legal reasons ☐ Immediate Care (Patient in Office, please fax)* ☐ Personal use
☐ Other _____

The above information to be disclosed by:

☐ **In office request** ☐ **Fax** ☐ **Mail** ☐ **Email**

*If Patient requests records to be faxed/emailed _____/_____
Signature of Patient/Authorized Representative Required Date

Statement Notice: 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 the Notice of Privacy Practices, a copy which has already been provided to me and I understand that I may refuse to sign this authorization. I also understand that the Cumberland County Department of Public Health cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization. I understand that once the 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. If you are requesting to receive your Protected Health Information electronically, we want to inform you that email communication can be intercepted in transmission by, or misdirected to a third-party. Cumberland County Department of Public Health is not liable for any damages resulting from the interception or misdirection of electronically transmitted PHI.

This authorization expires automatically upon 60 days, after the date signed.

Authorization Signature Required:

_____ _____ _____
Signature of Patient/Authorized Legal Representative Relationship to Patient Date