Authorization for Disclosure of Health or Billing Information

Patient Name ______________________ Medical Record Number ______________
Patient Address ______________________ Date of Birth ______________
City, State, Zip Code ______________________ Phone ______________

Organizations/People to provide information: (Attach additional sheets if needed)

- ☐ Presbyterian Hospital
- ☐ Presbyterian Hospital Matthews
- ☐ Presbyterian Orthopaedic Hospital
- ☐ Presbyterian Hospital Huntersville
- ☐ Forsyth Medical Center
- ☐ Medical Park Hospital
- ☐ Thomasville Medical Center
- ☐ Other (Specify) ______________

Organizations/People to receive information: (Attach additional sheets if needed. Include address if known.)

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Information to share:

- ☒ Name
- ☐ Age
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Progress/Office Notes
- ☐ Consultation
- ☐ Address
- ☐ Gender
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Report
- ☐ EKG/EEG/Cardiac Cath
- ☐ Phone Number
- ☐ Insurance Information
- ☐ Radiology Report
- ☐ Emergency Report
- ☐ Nurses Notes
- ☐ All of Medical Record
- ☐ Dates of Service (If Known/Requested) ______________
- ☐ Other (Specify) ______________

Release is full disclosure and may include drug, alcohol, psychiatric and sexually transmitted disease information including HIV/AIDS information unless excluded below.

Exclusions: ______________________________

How information is shared: ☐ In Person/Pick Up ☐ Fax ☐ Mail ☐ Other ______________

Why information is shared:

- ☐ Treatment
- ☐ Determine Disability
- ☐ Insurance
- ☐ Patient Request
- ☐ Worker's Compensation
- ☐ Other (Specify) ______________
- ☐ Legal Investigation

1. The person or organization that receives my information may not be required to follow federal privacy rules and might share my information. If this happens, my information may not be protected under federal privacy rules.
2. I can refuse to sign this authorization. Refusal will not change my ability to get treatment, payment for treatment or benefit eligibility. I can review or copy the information that is released.
3. I can change my mind and cancel this authorization by sending a written request to the Director of Medical Records who has this authorization. I cannot revoke this authorization for information that is released prior to cancellation.
4. I have read and understand this information. I have received a copy of this form. I am the patient or am authorized to consent for the patient.
5. This authorization is not for Research or Marketing releases.
6. This authorization will expire 90 days after I sign it unless a date or event is written here.
7. **NOTICE:** I understand that I may be charged in advance for shipping and/or other costs of copies or methods requested.

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Patient/Patient Representative Date

Legal Authority to sign for patient: ☐ Guardian ☐ Next of Kin ☐ Parent of Minor ☐ Attorney in Fact ☐ Executor ☐ Other (Specify) ______________

Patient is: ☐ Minor ☐ Disabled ☐ Deceased ☐ Incompetent ☐ Incapacitated

If limited English proficient or hearing impaired, offer interpreter:

☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

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Name / MR # / Label