

**Authorization to Disclose Protected Health or Billing Information**

Patient Name: \_\_\_\_\_ Patient Address: \_\_\_\_\_

Nickname/Maiden Name/Alias: \_\_\_\_\_

Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

**I give permission to:**

**To share my health information with:**

\_\_\_\_\_  
(Name of Person/Facility)

Mintview OBGYN

\_\_\_\_\_  
(Name of Person/Facility)

\_\_\_\_\_  
(Address)

**1918 Randolph Rd. Ste. 300**

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

**Charlotte, NC 28207**

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Phone number)

\_\_\_\_\_  
(Fax Number)

**704-377-5675**

\_\_\_\_\_  
(Phone number)

**704-335-8163**

\_\_\_\_\_  
(Fax Number)

**Check information to be shared:**

- Name
- Address
- Phone Number
- Insurance
- Social Security #
- Entire Medical Record

- History & Physical
- Laboratory Report
- Radiology Report
- Radiology Images
- Consultation
- Physician Dictation

- Nurses Notes
- Surgery Report
- Medication Records
- Progress Notes
- Discharge Summary
- Test Results

**Important Notice: This is a full release, including drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:** \_\_\_\_\_

Treatment Dates (must be a specific date or range of dates)

**Check reason to share health information:**  My (patient) request  Legal  Workers' compensation  Disability  Treatment:  
 Insurance Other (Describe) \_\_\_\_\_

**Share Information:**  In Person  Pick up  Fax  Mail  Other (Describe) \_\_\_\_\_

1. By law, Novant Health ("Novant") cannot use or share my health information without my permission, except by ways listed in Novant's Notice of Privacy Practices.
2. I can cancel this permission at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel the sharing of information already given as a result of this permission.
3. I do not have to sign this form. Refusal will not change my ability to get treatment, payment for treatment or benefits.
4. Once information is sent, it may not be protected by law. Someone may be able to share my information with others without my permission.
5. I have read, understand and, upon my request, been given a copy of this form.
6. This is not for use for Marketing or Research.

**NOTICE: There may be a fee charged to make copies of my medical record.**

**My permission ends 90 days after the date I signed, unless a date or event is written here:** \_\_\_\_\_

\_\_\_\_\_  
**Patient/Patient Representative Signature**

\_\_\_\_\_  
**Date**

**Legal Authority to**

**sign for patient:**  Healthcare agent  Guardian  Attorney in Fact  Parent  Next of Kin  Administrator/Executor

**If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.**

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

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter accepted \_\_\_\_\_  Interpreter refused

\_\_\_\_\_  
(Name/number of person/services chosen/used)



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**\*RI0010\***

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