DUPLIN COUNTY OFFICE OF EMERGENCY SERVICES
DIVISION OF EMERGENCY MEDICAL SERVICES
P.O. BOX 909, KENANSVILLE, NC 28349
(910) 296-2160 PHONE, (910) 296-2164 FAX

Authorization for Release of Protected Health Information

Patient name: ___________________________________ Patient date of birth: ___________________________

Date(s) of service: ____

This document authorizes and instructs the Duplin County Office of Emergency Services to furnish to:

____

(Print name of the person or entity authorized to receive the protected health information)

the following specific medical record(s) constituting protected health information (PHI) and its implementing regulations as amended:

___ All medical records, meaning every page in my record, including but not limited to patient care reports, history, physical, consultation and treatment notes, admission and discharge records, requests for and reports of consultations, photographs, diagrams, laboratory, histology, cytology, pathology, immunohistochemistry, and autopsy reports, radiology records and films, prescription records, and billing records, for the date(s) of service listed above (records release only).

___ Other information (specify): ____

I understand that the information contained in my health record to be released or disclosed may contain information relating to the treatment of drug and/or alcohol use/abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information, or genetics. I authorize the release or disclosure of this type of information UNLESS indicated here:

Signature: ____ Date: _________________________

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer subject to protection under law. The privilege I have to maintain the confidentiality of this PHI is not waived for any other organizations, individuals, or insurance companies not named herein. By affixing my signature below, I acknowledge that I release Duplin County and its individual departments, agents, and employees from any and all liability whatsoever in connection with this request to release medical records or information. A photocopy of this release may be used in place of the original.

This release expires six (6) months from the date listed below.

I understand that no healthcare provider named herein may condition treatment upon my execution of this written release.

I understand that this release may be revoked by me at any time in writing. However, any actions taken before the written revocation is received by any party in reliance upon this written release shall not be deemed invalid by reason of such later revocation.

I understand that I have a right to receive a copy of this signed written release.

I agree to pay the reasonable cost of copying and mailing associated with this request.

Signature form on next page

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Signature and Verification Requirements

Signature of Patient OR Authorized Representative: ______________________________

Date: __________________

I am: ___ the patient

___ the parent or legal guardian of the patient, whom is under 18 years of age

___ a court-appointed representative of the patient (must provide copies of court order(s))

State of ____________________ County of ___________________

Sworn and subscribed before me this _____ day of ________________, 20______.

By: ____________________________________

(SEAL)

(Notarization required for third-party or mail-in requests. Authorized court representative must provide a copy of appointing document from a court of competent jurisdiction.)

In lieu of notarization, verification requirements may be met by:

___ In-person patient request verified by government-issued photo identification. (copy of ID to be retained with request)

___ In-person request by authorized third party: parent, legal guardian, or other court-appointed representative verified by government issued photo ID and copy of appointing document. (copy to be retained with request)