MOREHEAD MEMORIAL HOSPITAL

# Authorization to Release Protected Health Information

| 117 E Kings Hwy Eden, NC 27288<br>MR#______________ Acct#___________ | Name (First, Middle, Last): | Birth Date (Month DD, YYYY) |
|---|---|---|

**Instructions: If ANY section is incomplete, this form may be invalid and the request cannot be processed.**

**Release Information From:**

☐Morehead Memorial
Attention ________________________________________
☐ Other (Specify Facility & Address Below, including phone /fax if known)
______________________________________________________________
______________________________________________________________
______________________________________________________________

**Release Information To:**

☐Morehead Memorial **Fax: 336-623-6902 Phone: 336-623-9711**
Attention ________________________________________
☐ Other (Specify Facility & Address Below, including phone /fax if known)
______________________________________________________________
______________________________________________________________
______________________________________________________________

**Purpose of Release:**

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes
☐ Application for Insurance ☐ Disability Determination ☐ Payment of Insurance Claim
☐ Other: ______________________________________________________________

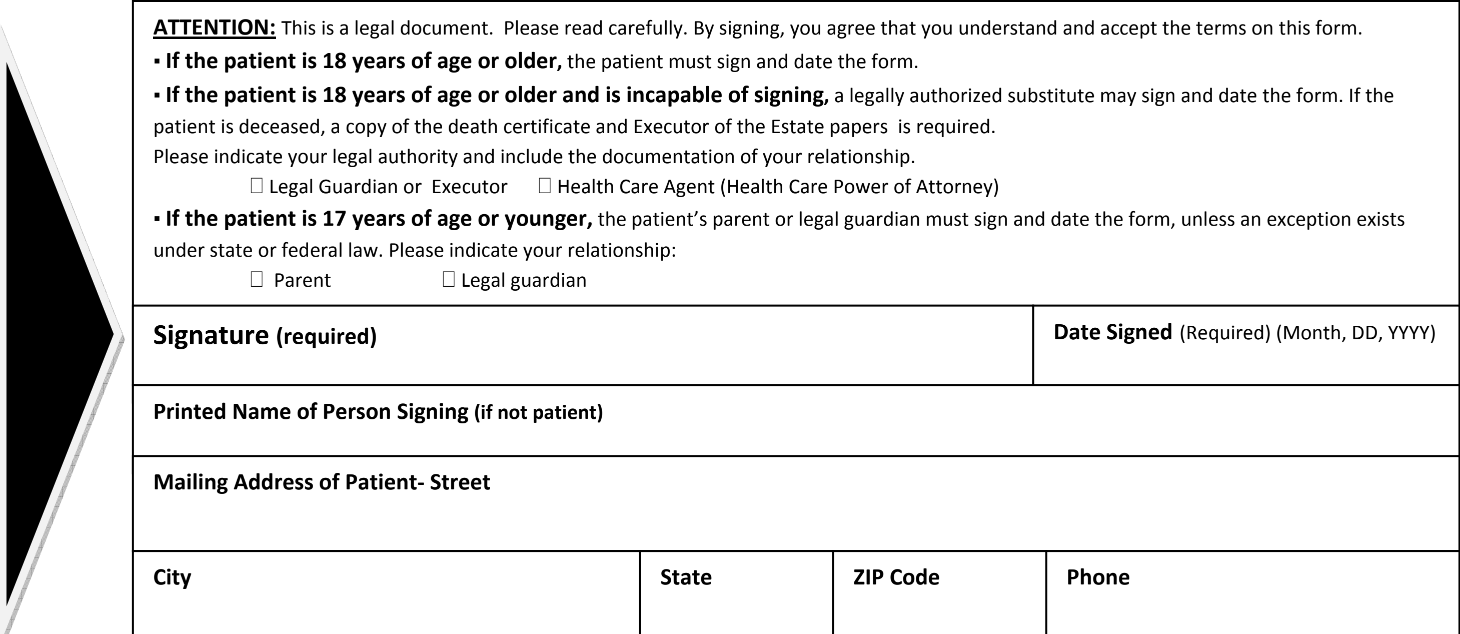
| Service Dates (approximate) | Information Needed By (specify date) |
|---|---|

☐ History and Physical ☐ EKGs ☐ Laboratory Reports ☐ Hospital Notes
☐ Immunization Records ☐ Pathology Reports ☐ Radiology Reports ☐ Occupational Health
☐ Emergency Dept. Records ☐ Operative Reports ☐ Hospital Discharge Summary
☐ Student Health Center ☐ Other: ______________________________________________

**I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDs, and genetics.**

**This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. I may be charged for copies in accordance to state law. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.**

**❋The authorization will expire one year from the date of signing unless I indicate a date or event here: _______________**



**ATTENTION:** This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. If the patient is deceased, a copy of the death certificate and Executor of the Estate papers is required.

Please indicate your legal authority and include the documentation of your relationship.
☐ Legal Guardian or Executor ☐ Health Care Agent (Health Care Power of Attorney)

- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

☐ Parent ☐ Legal guardian

| **Signature** **(required)** | | | **Date Signed** (Required) (Month, DD, YYYY) |
|---|---|---|---|
| **Printed Name of Person Signing (if not patient)** | | | |
| **Mailing Address of Patient- Street** | | | |
| **City** | **State** | **ZIP Code** | **Phone** |

Web