CONE HEALTH

HIPAA AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Last 4 SSN: XXX-XX-|__|__|__|__ **Telephone #:** _____

Address: _____

1. **I authorize Cone Health or _____ to disclose the following information to:**
   Name: _____ Telephone:_____Fax: _____
   Address: _____ City:_____State:____ ZIP: _____
   Email Address: _____
2. **Purpose of Disclosure:**
   ☐Patient Request ☐ Legal ☐ Other(specify)_____
3. **I authorize that my records be disclosed from the following Cone Health facilities (check as applicable):**
   ☐The Moses H. Cone Memorial Hospital ☐ Alamance Regional Medical Center ☐ Alamance Regional Cancer Center ☐Annie Penn Cancer Center ☐ Annie Penn Hospital ☐Cone Health Cancer Center ☐ MedCenter High Point ☐Wesley Long Hospital ☐Women's Hospital ☐Alamance Regional Medical Center Behavioral Health ☐Behavioral Health Hospital ☐Other:_____☐Cone Health Medical Group: _____
   (specify) *(practice name and/or provider name)*
4. **Dates of Service Requested:** From:_____/_____/_____ To: _____/_____/_____ or To: ☐ Future date of discharge of current episode.
5. **Information to be Disclosed**:
   ☐Dates of Service Only ☐Discharge Summary ☐History and Physical ☐Consultation Reports ☐Operative Notes ☐Progress Notes ☐Laboratory Results ☐X-Ray Reports ☐ED Visit ☐Substance Use Disorder Treatment Records ☐All ☐ Other (specify):_____
   ***Behavioral Health Specific**:* ☐Psychosocial History ☐Psychiatric Admission Assessment ☐Therapy Notes ☐Two-Way Communication ☐After Visit Summary (AVS) ☐Suicide Risk Assessment at Discharge ☐Other (specify): _____
6. **Manner of Disclosure**: (***There may be a fee charge for reproduction of medical records, films, and tapes***.)
   My records should be provided in the following manner (check all that applies): ☐ Print on paper ☐ CD/USB ☐ Mail to address above ☐ Fax to number above ☐ Pick up by the authorized recipient ☐Email to address above

PATIENT RIGHTS AND SIGNATURE

1. I hereby authorize the use or disclosure of my individually identifiable health information as described above. This includes information pertinent to sensitive information such as that related to my reproductive health, mental health, sexually transmitted diseases, genetic testing, drug/alcohol abuse, and HIV/AIDS diagnosis.
2. Substance Abuse Records: I understand that my alcohol and/or drug treatment records are protected by the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
3. I understand that this authorization is voluntary and that Cone Health cannot make me sign this authorization as a condition of receiving treatment from Cone Health except: (i) when Cone Health provides me with research-related treatment; or (ii) when Cone Health provides me with health care solely for the purpose of creating protected health information for disclosure to someone else and that disclosure is not permitted under HIPAA without a signed authorization.
4. I understand that once the information is disclosed pursuant to this authorization, the released information may no longer be protected by federal or state privacy regulations.
5. I understand this authorization will expire 1-year from the date signed unless an expiration date is otherwise stated here: _____.
6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing by mailing my revocation to: The Moses H. Cone Memorial Hospital; HIM Dept. – ATTN: ROI; 1200 N Elm Street; Greensboro, NC 27401. I understand the revocation will not apply to information that has been released pursuant to this authorization before Cone Health receives my written revocation.
7. I understand that, if I request my records to be mailed or e-mailed, my health information may not be secure during transit and could be viewed by someone other than me.
8. I understand there may be a charge associated with the Release of Information services rendered.

_____ _____
Signature Date

_____ _____
Name of person signing as: ☐ Parent ☐Guardian ☐ Authorized Representative *(attach copy of legal documents)* Date

OFFICE USE ONLY

Driver's License #	HIM Staff Signature	Date

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