Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center •Harvest Family Health Center •Wilson Community Health Center

Request for Protected Health Information- Medical

☐ Wilson Community Health Center
303 Green Street East
Wilson, NC 27893
252-243-9800

☐ Harvest Family Health Center
8250 South NC 58
Elm City, NC 27822
252-443-7744

☐ Freedom Hill Community Health Center
162 NC 33 East
Tarboro, NC 27886
252-641-0514

Please fax information to the following number: (252) 243-9888

Patient Name: ____
Last *First* *Middle*

Date of Birth: _____/_____/_______ **Medical Record Number**: ___________________________

I hereby authorize ____
Name of Agency or Doctor's Office

Address: ____

City: ______________________________________ **State:** _____________________ **Zip Code:** _______________

Office Telephone: ________/________/__________ Fax Telephone: __________/___________/__________

to release my medical information to Carolina Family Health Centers, Inc., as indicated below, for the purpose of continuity of care:

<u>INFORMATION TO BE RELEASED</u>

☐ **Discharge Summary, labs, radiology, and other diagnostic reports from the most recent hospitalization**
☐ **Progress note** Date range: From ___________________ to ____________________ or ☐ Last progress note only
☐ **Other:** ____ Date range: From _______________ to ______________

This authorization form meets the requirements for patient authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164, the federal drug and alcohol confidentiality law 42 C.F.R. part 2, and state confidentiality law governing mental health, developmental disability, and substance abuse services, G.S. 122C. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by state and federal law. I understand that the specified information to be released may include, but is not limited to, history, diagnosis, and treatment **of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS.** I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. This authorization expires in one (1) year unless otherwise specified.

____ ____________________________
Patient/Parent/Legal Guardian Signature *Date*
(Parent must sign for minor child)

____ ____________________________
Staff Signature (witness) *Date*