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

☐ Lee Student Health Center
200G Atlantic Christian College Dr. NE
Wilson, NC 27893
252-399-6493

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:

INFORMATION TO BE RELEASED

☐ **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*