Patient Name:	Last First Middle
Home Address:	
Home Telephone:	
Date of Birth:	**SSN:**
Dates of Service to be Released:	

Specify Information to be Disclosed:

❑ History and Physical ❑ Consultation ❑ Operative Report ❑ Discharge Summary
❑ Pathology Report ❑ Laboratory Reports ❑ Radiology Reports ❑ EKG Reports
❑ Electronic Copy of Medical Record. (via email or burned to a CD)
☐ Request that the information not be encrypted. (HIM employee to explain the risk involved with this)
❑ Other (please list): _____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

❑ Mental Illness _____
❑ Drug or Alcohol Abuse _____
❑ Developmental Disability _____
❑ Psychotherapy Notes _____
❑ HIV/AIDS Testing or Treatment (regardless of result) _____
❑ Venereal Disease _____
❑ Abuse of an Adult with a Disability _____
❑ Sexual Assault _____
❑ Child Abuse or Neglect _____
❑ Genetic Testing _____
❑ Other _____

RECIPIENT: **Name of person or class of persons to whom Frye Regional Medical Center may disclose my health information:**

ADDRESS**: Address of the recipient or where my health information should be delivered:**

TERM: **This Authorization will remain in effect:**

❑ From the date of this Authorization until the ___ day of _____, 20__.
❑ Until Covered Entity fulfills this request.
❑ Until the following event occurs _____
❑ Other _____

PURPOSE: I authorize Frye Regional Medical Center to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:

_____
_____

I understand that once Frye Regional Medical Center discloses my health information to the recipient, Frye Regional Medical Center cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Frye Regional Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Frye Regional Medical Center; except, however, if my treatment at Frye Regional Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Frye Regional Medical Center may refuse to treat me if I do not sign this Authorization. If my treatment is related to my participation in a research study, I understand that Frye Regional Medical Center may refuse to treat me if I do not sign this Authorization. I understand I would be permitted to designate an expiration date/event of "none".

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Frye Regional Medical Center's Health Information Management Director at 420 North Center Street Hickory, North Carolina 28601. The revocation will be effective immediately upon Frye Regional Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by Frye Regional Medical Center in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Frye Regional Medical Center to use or disclose my health information in the manner described above.

Signature of Patient _____ Date _____

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative _____ Description of Authority _____ Date _____

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records. If the patient has requested that the electronic information not be encrypted we have explained the risks involved with doing so.

Signature of employee validating identity _____