REQUEST FOR ACCESS TO OR AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) FROM CAPE FEAR VALLEY HEALTH SYSTEM (CFVHS)

PRINTED NAME:	BIRTH DATE:	SOCIAL SECURITY NUMBER:	PHONE:

TREATMENT DATE(S)	TREATING FACILITY ☐ CFV Medical Center ☐ Highsmith Rainey ☐ Behavioral Health Care ☐ Hoke ☐ Bladen ☐ Community Mental Health ☐ Betsy Johnson ☐ Central Harnett ☐ Clinic: _____ ☐ Other: _____

I authorize Cape Fear Valley Health System to **RELEASE TO**:_____
Name of Facility or Individual to RECEIVE Information

_____
Address Street City State Zip Code

Protected Health Information (PHI) to be disclosed from the above patient's medical record includes:

☐ Discharge Summary ☐ History and Physical ☐ Emergency Department/Express Care Records

☐ Operative/Procedure Reports ☐ Consultation Reports ☐ Labs, X-rays, EKGs ☐ Other:_____

☐ **I authorize the release of information contained in my record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date. (May require provider approval)**

☐ **I authorize the release of information contained in my record related to diagnosis and/or treatment for alcohol and/or drug abuse.**

☐ **I authorize the release of information contained in my record related to testing/treatment for communicable diseases including Hepatitis, STDs, AIDS, ARC (AIDS-related complex), or HIV.**

The purpose for releasing this information is: ☐ Health Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other_____

I understand the following:

- My health care and the payment for my health care will not be affected by signing this form.
- CFVHS may condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party, upon signing an authorization for disclosure of the PHI to such third party.
- CFVHS may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of PHI for such research.
- If the requester or receiver is not a health plan or healthcare provider, information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected be federal privacy regulations.
- I may revoke this authorization at any time in writing. Revocation of this release will not have any affect on any actions previously taken.
- CFVHS will provide me with a copy of this signed authorization.
- There may be a fee regulated by the state legislature for copying of my records, to include applicable taxes and mailing.
- There are risks with electronic delivery including misaddressed/misdirected messages; email accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security.

_____ _____ _____
Signature of Patient or Legal Representative Date Time

_____ _____
State Relationship to Patient Print Name
(Authorized representative must submit copies of legal documents supporting his/her authority to act on the patients behalf)

_____ _____ _____
Signature of Witness Date Time

_____
Print Name

This consent will automatically expire 90 days from date of signature, unless another date is specified below.

Authorization not valid beyond_____ (Date cannot exceed one year from date of signature)

☐ **Mail** ☐ **Pick-Up** ☐ **Electronic - Email Address:** _____

☐ **Electronic - CD** ☐ **Review on Site (I am not requesting a copy)**

Cape Fear Valley Health System
P.O. Box 2000 / Fayetteville, NC 28302–2000

Access/Authorization to Release PHI From CFVHS

TAB #15

CS0230

CS0230

Lawson #006938, FF0192; 07/98, 5/24/17, 9/30/24