CHAPEL HILL CHILDREN'S CLINIC

301 Kildaire Rd., Ste. 200, Chapel Hill, NC 27516
PH: (919) 967-0771 FAX: (919) 967-9207

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT NAME: ______________________________________ DATE OF BIRTH: _______________________

ADDRESS: (street, city, state, zip code)

____

I authorize **Chapel Hill Children's Clinic** to **obtain** Protected Health Information from:

____
Name of Physician's Office or Facility

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (include area code)

I authorize **Chapel Hill Children's Clinic** to **disclose** Protected Health Information to:

____
Name of Physician's Office or Facility

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (include area code)

Treatment Dates: ____________________________ Purpose of Request: _____________________

The following information is to be disclosed: (please check one box for each item)

YES	NO	
☐	☐	Chart Summary
☐	☐	Immunization Records
☐	☐	Physician Notes
☐	☐	Lab Results
☐	☐	X-Ray Reports
☐	☐	Complete Record
☐	☐	Other: ________________

SENSITIVE INFORMATION: I understand that the information in my or my child's record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include behavioral or mental health services or treatment for alcohol and drug abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I also understand that the revocation will not apply to information already released based on this authorization.

OTHER RIGHTS: (a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. (b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (if I do not specify an expiration date, event, or condition, this authorization will expire in six months.) Expiration date: ____________

Signature of Patient or Legal Representative: Date:

____ ______________________

If signed by Legal Representative, Relationship to Patient:

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