ANSON COUNTY HEALTH DEPARTMENT
POST OFFICE BOX 473
WADESBORO, NORTH CAROLINA 28170

Public Health
Prevent. Promote. Protect.

Patient Name:_____

Patient Social Security Number or Medical Record Number:_____

Patient Date of Birth:_____

PATIENT AUTHORIZATION
to Permit Use and Disclosure of
Health Information

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize Anson County Health Department to use or disclose to_____(please include complete name, address, email, telephone ,and fax number required to complete request)

the following protected health information *(identify the information in a specific and meaningful fashion)*:

The purpose of the use or disclosure is *(describe each purpose of the requested use or disclosure)*:

Please indicate media in which records sent from Anson County Health Department are to be delivered **(fax copy, paper copy to be picked up in person, mailed paper copy, email, electronic media)**: _____.
I have been advised that there may be a cost to provide medical record copies and this cost will be disclosed prior to preparing the documents for disclosure. Anson County Health Department cannot ensure the safety, security, and privacy for any medical record release that is provided via email. Additionally, all emails sent and received by Anson County Health Department are subject to Public Records Request and Review and may be subject to release to fulfill a public request. I have been advised of the factors concerning security & privacy of my request and I am accept all risk and responsibility as a result of the method I select in making the request and in the media I select to receive the request.

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in Anson County Health Department's Notice of Privacy Practices, a copy which has been provided to me.

I understand that I may refuse to sign this authorization. I also understand that Anson County Health Department cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization. I understand if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose, for up to one year, except for disclosures, for financial transactions, wherein, the authorization is valid indefinitely. I also understand I may revoke this authorization at any time (see our "Notice of Privacy Practices"). I further understand any action taken on this authorization prior to the rescinded date is legal and binding. I understand my information may include drug and/or alcohol use, testing for HIV/AIDS diagnosis, psychotherapy notes only with my specific consent, I also understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research related, treatment may be denied if authorization is not given. I further understand I may request of this signed authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon in one year from date signed:_____(please complete todays date)

_____
Signature of patient OR authorized representative

*Please print name of patient or authorized representative who signed above:*_____

Please explain representative's authority to act on behalf of the patient: _____

Interpreter's Signature:

Language:

Please print name of Interpreter:_____