Patient Name _____DOB___-___-___
Last First MI/Maiden Name
Treatment Dates_____ M #: _____ ID #: _____

I hereby consent to and authorize HARNETT HEALTH:

☐ **BETSY JOHNSON HOSPITAL** 800 Tilghman Drive Dunn, North Carolina 28334

☐ **CENTRAL HARNETT HOSPITAL** 215 Brightwater Drive Lillington, North Carolina 27546

to **RELEASE TO**:

_____
Name of Facility/Individual to RECEIVE Information

_____
Address

_____

Information concerning the history, treatment, examination and/or hospitalization of the above patient. I understand that the specific type of information to be released includes:

☐ Discharge Summary ☐ History and Physical ☐ Labs, X-Rays, EKGs
☐ Operative/Procedure ☐ ED Record ☐ Consultation Report
☐ Itemized Bills ☐ Other _____

And that information is needed for_____

I DO _____ **DO NOT** _____ **(PLEASE INITIAL)** authorize the release of portions of the record relating to substance abuse, psychological/psychiatric conditions and/or communicable disease, including Acquired Immunodeficiency Syndrome (AIDS), or tests for infection with Human Immunodeficiency Virus (HIV), if present.

I understand that this consent is revocable except to the extent that action has already been taken. This consent will automatically expire 90 days from date of signature, unless another date is specified below (*). **NOTE: UNLESS OTHERWISE PERMITTED BY LAW, FURTHER RELEASE OF THIS INFORMATION IS PROHIBITED WITHOUT MY PRIOR WRITTEN CONSENT.** ***Authorization not valid beyond** _____
(Date cannot exceed one year from today)

_____ _____
Signature of Patient or Legal Representative Relationship Date

_____ _____
Signature of Witness **Date**

Mail ☐ **Pick-Up** ☐ **Faxed** ☐ PHONE NUMBER/CONTACT for Questions: _____

County of _____ State of _____

Notary Signature: _____ My Commission Expires: _____
(Seal)

****AUTHORIZATIONS NOT SIGNED IN OUR MEDICAL RECORDS DEPARTMENT MUST BE NOTARIZED****

****WE WILL ONLY ACCEPT ORIGINAL (WET INK) AUTHORIZATIONS -- <u>COPIES WILL NOT BE ACCEPTED</u>****

HARNETT HEALTH SYSTEM

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT ID LABEL

AUTH