Harnett Health

AUTHORIZATION TO SECURE INFORMATION

Patient Name _____DOB___/___/___
Last First MI/Maiden Name
Treatment Dates_____ SSN _XXX / XX /_____

I hereby consent to and authorize:

_____
Name of Facility/Individual to RELEASE Information

_____
Address

_____

to release to Harnett Health 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
- ☐ Emergency Dept Record
- ☐ Consultation Reports

☐ Other (Specify): _____

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.

_____ _____
Signature of Patient or Legal Representative Date

_____
State Relationship to Patient

_____ _____
Signature of Witness **Date**

***Authorization not valid beyond**_____
(Date cannot exceed one year from date of signature)

PLEASE RETURN INFORMATION TO:

FAX NUMBER: 910-814-0303 OR 910-694-0101 **ATTN: _____**