Request/ Authorization for Release of Protected Health Information

J. Arthur Dosher Memorial Hospital 924 N. Howe St., Southport, NC 28461 Main Phone (910) 457-3800

Patient Name: (Print)_____ Date of Birth:_____
SS#:_____ Telephone:_____
Name/Address of Agency, Organization, or Individual to Whom Information is to be released:

_____

_____

_____

Requester wishes to: ☐inspect the record(s) ☐obtain copies ☐have copies mailed to address above
Appointment Date/time for Inspection/Pickup or Date needed to receive mailed copies:_____
Dates of information to be released:_____
Purpose / need for which PHI will be used:_____
Information requested: (Specify nature/extent of information to be released and/or check appropriate boxes.)

_____

Check all items that apply:

☐Concurrent Record: Staff Initial_____Advised that Record Incomplete
☐Nursing Center Documentation-List select NC forms and use Med. Record list
☐Discharge Summary
☐History & Physical Exam
☐Consultation Reports
☐ER Record
☐Billing Data: UB-92 I-Bill
☐Other:_____

☐Laboratory Results
☐Diagnostic Imaging Reports
☐EKG-CardioPulmonary
☐Operation Report
☐Pathology
☐Progress Notes
☐Physician Orders
☐Nursing Documentation

Please Read: I hereby request/authorize Dosher Memorial Hospital to release information as specified above. I understand that the information to be released may include information regarding substance abuse, sickle cell anemia, sexually transmitted diseases, psychological or psychiatric impairments, or AIDS-HIV related illness. I understand that PHI released pursuant to this authorization may be subject to re-disclosure and may not be protected by federal privacy rules. I understand that I may revoke this authorization in writing, sent to the Medical Record Department. I further understand that actions taken based on this authorization, prior to revocation, will not be affected.

This authorization will expire in 90 days. If this information is for my personal use, I understand that DMH has up to 30 days to respond to this request. If this request is to inspect a concurrent record, I am advised that it is an Incomplete Record. I understand that I ***may be charged a fee*** for copying and/or mailing costs to obtain copies of my protected healthcare information. I may assume that this request will be honored unless notified otherwise and I may receive a copy of this form upon request.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Name – Legal Representative Relationship of Legal Representative

Witness_____ Date_____

Hospital Use: Dosher Staff Releasing PHI:_____Date_____