**CHOCOWINITY FAMILY CARE**
***A Division of Beaufort County Hospital Association, Inc.***
***740 Bragaw Lane***
***Chocowinity, NC 27817***
***Tel: 252-946-9562*** ***FAX: 252-946-9071***

# AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.**

Facility authorized to **disclose** my health information: _____

Tel: _____ Fax: _____

Facility Authorized to **receive** my health information: _____

Tel: _____ Fax: _____

1. **Please release the following personal health information:**

   ___ Entire medical record other _____

2. **The information will be disclosed for the following purpose:**

   ___ Continuity of care ___ Transfer of care

   ___ Consultation ___ Other _____

3. I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect payment for or coverage of services, or my ability to obtain treatment, enrollment in the health plan, or eligibility of benefits. However, Chocowinity Family Care, a division of Beaufort County Hospital Assoc. Inc. may condition the provision of health care that is solely for the purpose of creating protected health care information on Patient's signing of this Authorization for the use and disclosure of protected health information created for research that includes treatment of the individual**.**

4. I understand that I may revoke this authorization at any time by notifying Chocowinity Family Care, a division of Beaufort County Hospital, in writing, except to the extent that:

   a.) Chocowinity Family Care, has already used the disclosed information in confidence on this authorization;
   or
   b.) if this authorization is obtained as a condition of obtaining insurance coverage.

5. I understand that I may inspect or copy the information used or disclosed, and I understand that I have a right to request and receive a *Joint Notice of Privacy Practices* from Chocowinity Family Care, a division of Beaufort County Hospital Assoc.Inc.

6. This authorization expires on _____ (date or event).

**I have read and understand this information. I will receive a copy of this form and am the Patient, or am authorized to act on behalf of the patient, to sign this document verifying authorization under the above stated terms.**

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient representative Relationship to patient, or representative's authority to act for the patient, if applicable

_____ _____
Signature of Witness Date of Birth or SS# of Patient

**You will receive a carbon copy of this form.**

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