Authorization for Disclosure of Health Information

I, the undersigned, authorize Women's Health Alliance to release my health information as noted below:

pka MID-CAROLINA OB/GYN
4414 Lake Boone Tr #300
Raleigh, NC 27607
Phone: 919-781-5510
Fax: 919-781-5053

Patient Information

*********All sections must be completed in order for request to be processed*********

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Charges outlined below will be applied for all copies released directly to patient . The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released

Please specify the information to be released:

☐ *Specify Date(s) of Service:*
_____

☐ *Entire Chart*

_____ *Initial Here*

I understand I will receive an invoice from BACTES Imaging per North Carolina Statutes and payment is made directly to BACTES Imaging Solutions. Questions about your request or invoice can be answered by calling 1-800-560-3800.

North Carolina General Statutes § 90-411

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling copying and mailing records to the Patient or the Patient's designated representative. The maximum fees are:

- ***$0.75 per Page*** for up to 25 Pages.
- ***$0.50 per Page*** for Pages 26 – 100.
- ***$0.25 per Page*** for Pages over 100.
- ***Minimum fee of $10.00*** permitted.

Authorization to Release Protected

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one *Initial each line below*

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
I ☐ **DO** ☐ **DO NOT** want information about _____ released _____
"Other sensitive information?"

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by **Women's Health Alliance** and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*