NORTH CAROLINA DIVISION OF PUBLIC HEALTH
HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Section A: This section must be completed for all Authorizations			
Patient Name:	**Date of Birth:**	**Identifier: MR#, Unique#, Barcode#**	**Patient or Representative Phone#:**
Healthcare Provider Name:	**Recipient's Name:**		
	Address 1:		
Healthcare Provider Address:	**Address 2:**		**Recipient's Phone:**
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Encrypted Email** ☐ **Unencrypted email**

Note: In the event the facility is unable to accommodate an email delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI via email.

Email Address (If email is checked above. Please print legibly):

Purpose of disclosure:

Description of information to be used or disclosed:			
Description:	**Additional Information Required: (Newborn Screening needs more data for verification)**		
	Date(s):	**Identifier: MR#, Sample#**	**Mother or Guardian Name*:**
☐ **Patient Final Report(s)**			*
☐ **Newborn Screening Collection Device**		*	*
☐ **Newborn Screening Dried Blood Spot**		*	*
☐ **Other:** _____			

*** Mandatory for the release of any Device, Dried Blood Spot, or Newborn Screening Report**

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results, or AIDS information. (_____) Initial

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.	☐ Yes ☐ No
Will the recipient receive financial remuneration in exchange for using or disclosing this information? If yes, describe:	☐ Yes ☐ No
May the recipient of the PHI further exchange the information for financial remuneration?	☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Patient's Representative:	Date:
Print Name of Patient or Patient's Representative:	Relationship to Patient:

Comment:

Submit completed form via Fax: 919-807-0730 or mail to NCSLPH, 4312 District Drive, Raleigh NC 27607. For assistance call 919-733-3937