Authorization to Disclose Protected Health or Billing Information

Patient Information: I give permission to release the health information of: **(One patient per form)**

Patient Name:_____ Date of birth:_____

Street Address:_____ Last 4 numbers of SSN:_____

City, State, Zip:_____ Telephone: (____)_____

Email address:_____

Although Highland Primary Care uses reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release Information From:	**Release Information To:** Highland Primary Care — Self
(list applicable Facility(s) and/or Practice(s))	(Name of facility, person, company) — (Relationship)
	513 Lauchwood Drive, Laurinburg, NC, 28352 (Street address or PO Box, City, State, Zip code)
	(910) 506-4510 (Phone number) — (910) 506-4527 (Fax number)

Purpose of Release (check reason): ☒ Request of individual / personal ☐ Insurance ☐ Disability ☐ Workers Compensation

☐ Legal purpose including discussions & proceedings ☐ Other:_____

Must fill in dates of treatment for records to be released: Treatment dates FROM:_____ TO:_____

Hospital (check all that may apply):

☐ **Hospital Abstract**

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Diagnostic Test Results
- ☐ Medications
- ☐ Allergies
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Emergency Record
- ☐ Cardiac Reports/EKG
- ☐ Laboratory Reports
- ☐ Radiology/X-Ray Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Other:_____

☐ Entire Record (not including psychotherapy notes)

Office/Clinic (check all that may apply):

☐ **Office / Clinic Abstract**

- ☐ Office Visits
- ☐ Physical Exam
- ☐ Consultation Reports
- ☐ Diagnostic Test Results

☐ Laboratory Reports
☐ Radiology Reports
☐ Medications
☐ Billing Information
☐ Other:_____

☐ Entire Record (not including psychotherapy notes)

Format (only select one):

☐ Paper copy (charges may apply) ☒ Electronic copy
☐ CD (charges may apply) ☐ Other:_____

Delivery Method:

☐ Reg. US Mail ☐ Pick-up ☐ Email ☒ Fax
☐ Other:_____

I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

Signature:_____ **Print name:**_____ **Date/Time:**_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Parent ☐ Next of Kin

☐ Other:_____

Signature of minor:_____ **Print name:**_____ **Date/Time:**_____

For office use only

Date of release:_____ via ☐ mail ☐ fax ☐ other_____ ☐ ID verified ☐ DL/Other ID_____

HPC Employee Name & Title:_____ HPC Employee User ID:_____ Date/Time:_____