AUTHROIFR Rev. 08/13

Catawba Valley Medical Center

*ROIAUTH

ROIAUTH

Authorization For The Disclosure Of Protected Health Information From Catawba Valley Medical Center

Patient Name: _____ Date of Birth: _____ MR#: _____

The information requested includes: **Date(s) of service from** _____ to _____

***********Note: Please send the most recent records for the following***********

❑ **Abstract (DS, HP, OP, Path)**	❑ **Discharge Summary**	❑ **Operative Report**
❑ **History and Physical**	❑ **Consultation Report**	❑ **ER Record**
❑ **Progress Notes**	❑ **Laboratory Reports**	❑ **X-ray Reports**
❑ **Rehabilitation Notes**	❑ **Echocardiogram**	❑ **Stress Test Results**
❑ **EKG**	❑ **X-Ray Imaging &/or Results**	❑ **Other: _____**
❑ **Last Pacemaker/ICD interrogation**		

By applying a check and initialing next to a category of highly confidential information listed below, I specifically authorize release of information on (patient/representative must initial applicable area):

_____ ❑ AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus)

_____ ❑ Drug, Alcohol, and/or Psychiatric treatment records

❑ Do not release: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization and I am providing this authorization under my free will. I understand that once the authorized organization or person receives this information, then this information may be subject to re-disclosure, and may no longer be protected by federal or state law. Catawba Valley Medical Center may not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this form unless treatment is research related and such disclosure is for research purposes or unless the provision of health care was solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for such disclosure.

I, _____, hereby consent to and authorize Catawba Valley Medical Center to use or disclose to the following {please state name or specific identification of the person(s) or class of the person(s)} _____ for the purpose of:

_____.

This authorization will remain in force for **sixty (60)** days from the date indicated below.

I understand that I may revoke this authorization in writing. However, the revocation is not effective to the extent that the entity or person using or disclosing information has already relied on this authorization or during an insurance contestability period, if applicable. Written requests for revocation may be sent to the Chief Privacy Office for Catawba Valley Medical Center at 810 Fairgrove Church Road, SE, Hickory, North Carolina, 28602, telephone (828) 326-3294.

_____ / _____

Signature of Patient/Parent (for minor child)/Legal Guardian/Authorized Legal Representative Date

If signed by someone other than the patient, please state relationship and authority to sign:

_____