

**REQUEST FOR ACCESS TO OR AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)  
FROM CAPE FEAR VALLEY HEALTH SYSTEM (CFVHS)**

<b>PRINTED NAME:</b>	<b>BIRTH DATE:</b>	<b>SOCIAL SECURITY NUMBER:</b>	<b>PHONE:</b>
<b>TREATMENT DATE(S)</b>	<b>TREATING FACILITY</b> <input type="checkbox"/> CFV Medical Center <input type="checkbox"/> Highsmith Rainey <input type="checkbox"/> Behavioral Health Care <input type="checkbox"/> Hoke <input type="checkbox"/> Roxie Avenue Detox Center <input type="checkbox"/> Bladen Healthcare <input type="checkbox"/> Clinic: _____ <input type="checkbox"/> Other: _____		

I authorize Cape Fear Valley Health System to **RELEASE TO:** \_\_\_\_\_  
 Name of Facility or Individual to RECEIVE Information

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Protected Health Information (PHI) to be disclosed from the above patient's medical record includes:**

- Discharge Summary       History and Physical       Emergency Department/Express Care Records  
 Operative/Procedure Reports       Consultation Reports       Labs, X-rays, EKGs       Other: \_\_\_\_\_

- I authorize the release of information contained in my record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date. (May require provider approval)  
 I authorize the release of information contained in my record related to diagnosis and/or treatment for alcohol and/or drug abuse.  
 I authorize the release of information contained in my record related to testing/treatment for communicable diseases including Hepatitis, STDs, AIDS, ARC (AIDS-related complex), or HIV.

The purpose for releasing this information is:  Health Care     Legal     Insurance     Personal     Other \_\_\_\_\_

**I understand the following:**

- My health care and the payment for my health care will not be affected by signing this form.
- CFVHS may condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party, upon signing an authorization for disclosure of the PHI to such third party.
- CFVHS may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of PHI for such research.
- If the requester or receiver is not a health plan or healthcare provider, information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
- I may revoke this authorization at any time in writing. Revocation of this release will not have any effect on any actions previously taken.
- CFVHS will provide me with a copy of this signed authorization.
- There may be a fee regulated by the state legislature for copying of my records, to include applicable taxes and mailing.
- There are risks with electronic delivery including misaddressed/misdirected messages; email accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security.

\_\_\_\_\_  
Signature of Patient or Legal Representative      Date \_\_\_\_\_      Time \_\_\_\_\_

\_\_\_\_\_  
State Relationship to Patient      Print Name \_\_\_\_\_  
(Authorized representative must submit copies of legal documents supporting his/her authority to act on the patients behalf)

\_\_\_\_\_  
Signature of Witness      Date \_\_\_\_\_      Time \_\_\_\_\_

\_\_\_\_\_  
Print Name

**This consent will automatically expire 90 days from date of signature, unless another date is specified below.**

**Authorization not valid beyond** \_\_\_\_\_ (Date cannot exceed one year from date of signature)

- Mail     Pick-Up       Electronic - Email Address: \_\_\_\_\_  
 Electronic - CD       Review on Site (I am not requesting a copy)

**Cape Fear Valley Health System**  
P.O. Box 2000 / Fayetteville, NC 28302-2000

Access/Authorization to Release PHI  
From CFVHS

TAB #15

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