Authorization to Discuss Information with Others

Patient's Name: _____ Date of Birth: _____

MRN: _____

I, _____, do hereby authorize Coastal Carolina Health Care to disclose to the person(s) noted below information relating to my healthcare.

The information which may be shared includes information taken from:

☐ Medical record ☐ Billing record ☐ Other: _____

Medical record information includes information taken from office visit notes, consultation reports, lab results, and diagnostic, procedure, and radiology reports, and other health information located in the patient health record.
I understand information released may include sensitive information related to behavioral and/or mental health records, drugs and alcohol, pregnancy, HIV/AIDS and other communicable diseases, cancer related illnesses and genetic testing.

Person(s) to whom the above information may be discussed/shared with:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I understand that I may revoke this Authorization at any time. The revocation will not apply to information that has already been released in response to this Authorization or to my insurance company. If I revoke this Authorization, I must do so in writing and submit my revocation to my provider's office. If I have further questions, I may contact CCHC Privacy Officer. Phone (252) 514-6685, e-mail: privacy@cchealthcare.com. Unless otherwise revoked, this authorization will be in effect as long as I am a patient at CCHC.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. CCHC employees, officers and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Patient or Representative Signature: _____ Date: _____

Printed Patient's Name: _____

Printed Representative's Name: _____ Relationship to Patient: _____

*Description of Personal Representative's Authority (attach necessary documentation) _____

CCHC's Representative Signature (Witness): _____ Date: _____