

WAKE COUNTY AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TO: Medical Records Custodian
Name of Department: Emergency Medical Services
Wake County

PATIENT NAME: _____

PATIENT DOB: _____

DATE(S) OF SERVICE: _____

This document authorizes and instructs the Wake County Department of Emergency Medical Services to furnish to:

(Insert the name of the person or entity authorized to receive the protected health information)

(Insert the address of the person or entity authorized to receive the protected health information)

the following specific medical record(s) constituting protected health information (“PHI” as that term is defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA – P.L. 104-191) and its implementing regulations, as amended :

_____ All medical records, meaning every page in my record, including but not limited to patient care reports, history, physical, consultation and treatment notes, admission and discharge records, requests for and reports of consultations, photographs, diagrams, laboratory, histology, cytology, pathology, immunohistochemistry, and autopsy reports, radiology records and films, prescription records, and billing records, for the date(s) of service listed above (records release only)

_____ Other information (specify)_____

I understand that the information contained in my health record to be released or disclosed may contain information relating to the treatment of drug and alcohol use/abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information, or genetics. I authorize the release or disclosure of this type of information **unless** indicated here: (Signature):_____ (Date)_____.

The purpose(s) of this requested use or disclosure is/are:

(The statement “At the request of the individual” is a sufficient description if the individual does not wish to disclose the purpose)

I understand that even with my authorization, Wake County shall only release protected health information in accordance with Wake County’s Individual Right to Access PHI procedure and applicable HIPAA law.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer subject to protection under law. The privilege I have to

maintain the confidentiality of this PHI is not waived for any other organizations, individuals, or insurance companies not named herein. By affixing my signature below, I acknowledge that I release Wake County and its individual Departments, agents, and employees from any and all liability whatsoever in connection with this request to release medical records or information. A photocopy of this release may be used in place of the original.

This release expires six (6) months from the date below.

I understand that no healthcare provider named herein may condition treatment upon my execution of this written release.

I understand that this release may be revoked by me at any time in writing. However, any actions taken before the written revocation is received by any party in reliance upon this written release shall not be deemed invalid by reason of such later revocation.

I understand that I have a right to receive a copy of this signed written release.

I agree to pay the reasonable cost of copying and mailing associated with this request.

SIGNATURE AND VERIFICATION REQUIREMENTS:

Signature of Patient or Authorized Representative: _____

Date: _____

- I am the patient
- the parent of the patient, who is under 18 years of age
- an authorized court-appointed representative of the patient

State of _____ County of _____

Sworn and subscribed before me this _____ day of _____, 20____.

BY: _____ (SEAL)

Notary Public or other officer authorized to take and certify acknowledgments and administer oaths.

(Notarization required for third party or mail in request. Authorized court representative must provide a copy of appointing document from a court of competent jurisdiction)

In lieu of Notarization, verification requirements may be met by the following:

_____ In-person patient request verified by government-issued photo identification (copy of ID to be retained with request)

_____ In-person request by authorized third party - parent, legal guardian, or other court-appointed representative verified by government issued photo ID and copy of appointing document (copy to to be retained with request)