Coastal Carolina Neuropsychiatric Center

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH RECORDS

Patient Name: _____ Patient DOB: _____

I hereby authorize the use and disclosure of protected health information as described below:

(1) Identify those one or more persons/organizations ("Covered Entity," whether one or more) authorized to use or disclose your information: Coastal Carolina Neuropsychiatric Center, P.A.

(2) Identify those persons/organizations authorized to receive your information:

_____

_____

(3) Provide a specific description of your information to be used and disclosed (check applicable box):

☐ All of my individually identifiable health information for all dates of service, including but not limited to all medical records, mental health records, records of communicable diseases (including HIV/AIDS), physician notes, examination records, sexual assault evidence collection information, diagnostic records, clinical lab test results, observations, opinions, treatment records, billing records, and communications

☐ Other (specify below):

_____

(4) The purpose of this HIPAA Authorization is at my request.

(5) I understand that I may revoke this HIPAA Authorization at any time by delivering a written, signed revocation to Coastal Carolina Neuropsychiatric Center, P.A., Attention: Privacy Officer, 200 Tarpon Trail, Jacksonville, NC 28546; however, such revocation does not affect any actions taken by Covered Entity before my written revocation is received by Covered Entity.

(6) I understand that the information used or disclosed pursuant to this HIPAA Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

(7) I understand I am entitled to receive a copy of this HIPAA Authorization form after I sign it.

(8) Unless revoked earlier, I understand that this HIPAA Authorization will expire one year following the date I sign it.

(9) I understand that this HIPAA Authorization is voluntary, that I have the right to refuse to sign it, and that Covered Entity may not refuse to treat me if I do not sign it.

_____ _____

Signature of Patient/Representative Date

Coastal Carolina Neuropsychiatric Center

If the patient cannot complete and execute this form, HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH RECORDS at the offices of Coastal Carolina Neuropsychiatric Center, P.A. in the presence of office staff, the patient must execute this form in the presence of a notary and return the notarized form to Coastal Carolina Neuropsychiatric Center, P.A.

_____ COUNTY, NORTH CAROLINA

I certify that the following person personally appeared before me this day, acknowledging to me that he signed the foregoing document: _____

Date_____ _____

Notary Public

(Official Seal)

My Commission Expires:

_____