# Authorization to Disclose Protected Health Information

The undersigned authorizes:

COASTAL VASCULAR INSTITUTE

**Coastal Vascular Institute, PA**
**1411 Physicians Drive**
**Wilmington, NC 28401**
**Phone: 910-343-0811 Fax: 910-343-5719**

to release my health information as noted below.

***All sections must be completed in order for request to be processed****

## Patient Information

**Patient Full Name:** _____ **Date of Birth:** _____

Patient Address: _____ Other Names? _____

City: _____ State: _____ Zip: _____ Phone #: _____

## Release Information To (THIS SECTION MUST BE COMPLETED)

**Name/Facility:** _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax:** _____

**Purpose of Request:** ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐

## Information to be Released (THIS SECTION MUST BE COMPLETED)

*If you fail to specify, 1 year of records will be provided.*

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports

Specify Date(s) of Service: _____

☐ **Entire Chart**

☐ **Other** (please specify):

_____

***Questions about your request or invoice can be answered by calling:* JANE THOMAS at 910-343-0811 ext. 116**

**Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.**
**At no time will the cost-based fees exceed NC law (Statute: §90-411).**

**I understand I will be responsible for the charges incurred in the release of my protected health information.**

***Rates are determined by Delivery Method Selected.***
****** PAYMENT OPTIONS: Check, Credit Card or Money Order***

| | | | |
|---|---|---|---|
| DELIVERY METHOD | [ ] Fax [ ] Pick-up [ ] Mail | TYPE | [ ] Paper [ ] CD |

*Our Medical Records Department will determine the delivery method based on the information provided on this form.* **No charge** for records being released to another healthcare provider.

## Authorization to Release Protected Health Information

**I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.*** _____ *(Please Initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____. *If I do not specify expiration this authorization will expire in 1 year.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP

**Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

**Signature*:** _____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*