



ENC Peds HIPAA Authorization

Authorization to release the protected health information of:		
Patient Name:	DOB:	
Current Address:		
City:	State:	Zip:
Phone Number:		
This authorization is to release the protected health information to:		
Name:	Phone Number:	
Address:		
City:	State:	Zip:
Delivery By:	<input type="checkbox"/> Mail	
	<input type="checkbox"/> Fax:	
	<input type="checkbox"/> Email:	
This authorization is to release the protected health information from:		
Facility Name/Provider:		
Phone Number:		
Address:		
City:	State:	Zip:
The purpose of this disclosure: <input type="checkbox"/> at patient's request <input type="checkbox"/> Other as specified here:		
Dates of service requested:		
I authorize the release of the following information:		
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Mental/behavioral health note(s)	
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Therapy notes (PT, OT, Speech)	
<input type="checkbox"/> Consultations	<input type="checkbox"/> Allergies and Medications Lists	
<input type="checkbox"/> Operative reports	<input type="checkbox"/> Immunizations	
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Substance abuse and Addiction Treatment records	
<input type="checkbox"/> Pathology reports	<input type="checkbox"/> Lab Reports (including HIV and genetic results)	
<input type="checkbox"/> Radiology reports/Images	<input type="checkbox"/> Billing/Financial information	
<input type="checkbox"/> Other as specified here:		
This Authorization will remain in effect until either:		
Date or Event:		

I understand that:

- This authorization may be revoked at any time by providing written notice of revocation to ENC Peds, except to the extent providers have already taken action in reliance on it. Such written notice may be provided to the HIPAA Privacy Officer of ENC Peds by mailing a copy to [address] or delivering a copy to [address] and leaving it with [identity of person with whom the revocation should be left]. My written revocation does not affect any actions taken by ENC Peds before it received my written revocation.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal Privacy Rule or other federal privacy regulations and applicable state or federal laws.
- ENC Peds will not condition my treatment on whether I provide authorization for the requested use or disclosure, except in limited circumstances (e.g. if the treatment is research-related or the treatment is necessary for the purpose of creating protected health information for disclosure to a third party, such as physical examinations for school, camp, and employment purposes).

I may request a copy of this signed authorization.

If I have questions about disclosure of my health information, I can contact ENC Peds at 252-484-9024.

Note: A patient (18 years or older) must authorize the release of their own information unless the patient is incapacitated or deceased. If signing for a minor patient, I hereby affirm that my parental rights have not been revoked by a court of law.

This section required to be completed:	
Signature:	Date: (mm-dd-year)
Printed Name of person signing:	
Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Health Care Power of Attorney/Agent <input type="checkbox"/> Other: _____	