Carolina Center *for* Restorative Medicine

Restoring Hope and Health with Heart

Authorization to Use and Disclose Protected Health Information

809 Spring Forest Road, Suite 100
Raleigh, NC 27609
www.ccrmraleigh.com
info@ccrmraleigh.com
P 919-803-4268 | F 919-977-1381

Instructions: Carolina Center for Restorative Medicine is HIPAA compliant. We take seriously our legal obligation to protect confidential patient information. We give all patients the opportunity to read our HIPAA Notice of Privacy Practices (NPP) and ask for their written acknowledgment. Please help us maintain our respect for patient privacy and comply with the law by completing this authorization form.

I have had the opportunity to read Carolina Center for Restorative Medicine's Notice of Privacy Practices regarding the use and disclosure of protected health information (PHI). I understand that I may refuse to sign this authorization to release PHI and that my refusal to sign will in no way affect my treatment, payment, enrollment in a health plan, or eligibility for benefits. I also understand that my signature is required in order to complete this request.

Carolina Center for Restorative Medicine may use and disclose my PHI only for the specific purpose identified below or until the completion of the event for which I have provided the authorization. For example, if I authorize the use and disclosure of the information because I have been referred to another physician, that's the only purpose for which the use and disclosure can be made. My authorization is not a blanket permission to use and disclose PHI for any other purpose.

At all times, I retain the right to revoke this authorization to use and disclose PHI. Should I wish to exercise this right, I will submit a written request to the Carolina Center for Restorative Medicine Practice Administrator.

I understand that the party that receives my PHI may re-use or re-disclose the information received. At that point, the PHI may no longer be protected under federal or state confidentiality rules.

I understand that Carolina Center for Restorative Medicine will charge a fee for copying the medical records for which I have provided authorization for use and disclosure.

I have read the information related to use and disclosure and understand that I may request a copy of this form if desired.

Medical Record Number: (to be filled in by practice) ______________________________

Patient Name: ______________________________ Maiden Name: ____________________

Date of Birth: ____________

Address: ____

____

Telephone: Home ________________________ Cell ______________________ Work ______________________

As the patient or the individual authorized to act on behalf of the patient, I authorize the use and disclosure of the following protected health information (PHI) relating to me as described below.

I, (NAME)____, hereby authorize Carolina Center for Restorative Medicine to release the following information:

- ◯ Office Notes
- ◯ Entire Chart
- ◯ Pathology Report
- ◯ Lab test results

Release information to: ____

____

____

Patient Name or Name of Individual Authorized to Act on Patient's Behalf:

____

Printed Name: ____

Date: ____________________________________