Authorization to Disclose Protected Health or Billing Information

Patient Information: I give permission to release the health information of: **(One patient per form)**

Patient Name: ______________________ Date of birth: ____________

Street Address: ______________________ Last 4 numbers of SSN: ____________

City, State, Zip: ______________________ Telephone: (   ) ____________

Email address: ______________________

Although Novant Health will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release Information From:	Release Information To:
(list applicable Facility(s) and/or Practice(s))	(Name of facility, person, company) (Relationship)
	(Street address or PO Box, City, State, Zip code)
	(Phone number) (Fax number)

Purpose of Release (check reason): ☐ Request of individual / personal ☐ Insurance ☐ Disability ☐ Workers Compensation ☐ Legal purpose including discussions & proceedings ☐ Other:____________________

Must fill in dates of treatment for records to be released: Treatment dates FROM:______________ TO:______________

CHOOSE ONE: I would like the parts of my record selected below to be released:

Option 1:	OR	Option 2:	OR	Option 3:
☐ **Treatment Summary** (Abstract) *includes all physician notes, orders and results from the location and dates of service indicated above.		**Partial Record** (choose specific items below if you do not need the entire chart or abstract) **Physician Notes:** ☐ All ☐ History & Physical ☐ Progress Notes ☐ Office Notes ☐ Discharge Summary ☐ Operative/Procedure Notes ☐ ER Notes ☐ Consultation Notes **Orders and Results:** ☐ All ☐ Cardiac/EKG ☐ Laboratory ☐ Diagnostic Testing ☐ Radiology/X-ray ☐ Pathology ☐ **Medications** ☐ **Other:**		☐ **Entire Record** (not including psychotherapy notes)

Additional Options:

☐ Billing Information ☐ Estimates
☐ Certification of Records ☐ Certification and Affidavit of Records
☐ Radiology Images (CD)

*CDs containing radiology images are separate from a medical records CD and charges apply.

Delivery Method: **Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):**

☐ MyChart (only available to patients) ☐ NH LINK (only available to 3rd party)
☐ Fax ☐ E-mail ☐ Paper Copy via USPS ☐ CD/DVD ☐ Other: ______________

Send Completed Form To:

Mailing Address:
Email: ROIenterprise@novanthealth.org
Phone (Toll Free) 1-844-763-9163 **Fax** 1-704-316-9556
Novant Health Release of Information, P.O. Box 7688, Charlotte, NC 28241

Visit https://www.novanthealth.org/medicalrecords for additional information.

☐ Patient Waiting (onsite pick up) *Novant Health clinics and hospitals may only be able to release a limited amount of records onsite. All other requests are processed by the Novant Health Enterprise Release of Information department.

I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, enrollment in health plan, or eligibility for benefits.**
- **A fee may be charged for providing the protected health information. Please visit our website above for a list of fees.**
- **I have a right to receive a copy of this form upon request.**

This permission expires 90 days after the date of my signature unless another date or event is written here:______________

Signature: ______________ **Print name:** ______________ **Date/Time:** ______________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
If you are not the patient or the parent of a minor patient, you MUST attach documentation of your authority to act on behalf of the patient.

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Parent ☐ Next of Kin ☐ Other: __________

Signature of minor: ______________ **Print name:** ______________ **Date/Time:** ______________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)