Authorization for Disclosure of Protected Health Information

Patient's Name: _____ Date of Birth: _____

I do hereby authorize:

☐ Northern Hospital of Surry County	☐ Northern Pediatrics Center	☐ Blue Ridge Bone & Joint Center
☐ Northern Gastroenterology	☐ Surry Urological Associates	☐ Surry Medical Specialists
☐ Mount Airy OBGYN Center	☐ Surry Surgical Associates	☐ Revival
☐ Other agency or physician: _____		

Please release the following health information: (Please describe date and/or specific information.)

_____

Please release the information to:

Name of Person or Facility/Department to receive health information: _____

Address: _____

Telephone #: _____ Fax #: _____

Fax #: Northern Hospital HIM (Medical Records) Dept (336) 719−7456; Northern Hospital Emergency Dept (336) 789−5495;
Northern Pediatrics Center (336) 786−3796; Blue Ridge Bone & Joint Center (336) 719−0714; Northern Gastroenterology (336) 786−6747;
Surry Urological Associates (336) 786−3795; Surry Medical Specialists (336) 786−8973; Mt. Airy OBGYN Center (336) 789−3025;
Surry Surgical Associates (336) 786−3778; Revival (Elkin) (336) 835−5337; Revival (Mt. Airy) (336)783−8035.

The purpose of this release is:

☐ Continuity of care	☐ Insurance	☐ Legal	☐ School/Work release	☐ Other: _____ (Please specify)

I authorize the use or disclosure of my protected health information as described above.

I have a right to receive a copy of this authorization. I am signing this authorization voluntarily. I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to the Health Information Management Department of Northern Hospital of Surry County. I understand a revocation will not reverse any action taken in reliance upon this authorization. This authorization will expire in six months after the date of signing. I understand that the information disclosed pursuant to this authorization may include information concerning mental health, use or treatment concerning drugs and/or alcohol abuse under 42 CFR Part 2, HIV/AIDS, and/or other communicable disease, and genetic testing results.

I understand that the information disclosure pursuant to this authorization may be re−disclosed by the person(s) receiving this information and the information disclosed may no longer be subject to protection by federal privacy regulations or other laws.

Signed by Patient: _____	Date: _____
Signed by Personal Representative: _____	Date: _____
Witness: _____	Date: _____

NORTHERN HOSPITAL OF SURRY COUNTY

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