EAST CAROLINA UNIVERSITY HEALTH CARE COMPONENTS

Authorization for Use or Disclosure of Protected Health Information

Name: **Date of Birth:**

Address: _____ **Phone Number:** _____

I authorize _____ to (Check one box below):

(Print Name of ECU Health Care Component or Provider)

☐ **Use or disclose a copy of my specific (PHI) identified below to:**

_____

(Print Name of Person(s) or Entity(s) Authorized to Receive PHI)

_____

(Print Address and Phone Number of Name or Entity Authorized to Receive PHI)

OR

☐ **Request a copy of my specific PHI from:** _____

(Print Name of Person/Facility Authorized to Forward PHI)

_____

(Print Address and Phone Number of Person/Facility Authorized to Forward PHI)

The purpose of this authorization is for: _____

By initialing the spaces below, I specifically authorize the use or disclosure of the following PHI:

☐ Entire Medical/Dental Record ☐ Laboratory Reports

☐ Office Visit(s)-Specify dates of service: _____

☐ Radiology Reports ☐ Pathology Reports

☐ Other: _____

The following items must be initialed to be included in this request for use or disclosure:

☐ HIV/AIDS related information ☐ Genetic testing information

☐ Mental health information ☐ Alcohol and drug abuse program records

☐ Psychotheropy Notes. If Psychotherapy Notes is selected, no other item may be selected. A separate form must be completed. Psychotherapy notes use or disclosure is at the discretion of the author of the note.

I have read and understand this information. I understand that, if the person or organization receiving this information is not a health care provider, health care organization, or health plan covered by federal privacy regulations, then my PHI may be re-disclosed and no longer be protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I am the patient or I am the personal representative of the patient and am authorized to sign this document authorizing the use or disclosure of Protected Health Information under the above terms. I have received a copy of this form if an ECU Health Care Component has requested an authorization from me for use or disclosure of protected health information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. Please forward a written request or complete a Revocation of Authorization for Use or Disclosure of PHI and return to: ECU Privacy Office, Physicians Quadrangle N, 600 Moye Blvd, Greenville, NC 27834.
Unless revoked earlier, this **authorization will expire on:** _____

(Enter Date OR Specific Event, i.e., sending as requested above)

Date: _____ _____

Signature of Patient

_____

Signature of Person Signing of Behalf of Patient **Print Name**

_____

Legal Relationship to Patient

Return this request to:ECU School of Dental Medicine, Office of Clinical Affairs
1851 MacGregor Downs Road Greenville, NC 27832-4354