

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I consent to the disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

****Please check all that apply:***

- All my medical information
- Information necessary to schedule appointments for me
- Labs or test results
- Information necessary to provide, call in or pick up prescriptions for me
- Information necessary to help my family member(s) take care of me
- Information necessary to allow my family member(s) too pick up or arrange for medical equipment to be provided for me
- Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

Name: _____ Ph #: _____ Relation: _____

Name: _____ Ph #: _____ Relation: _____

Name: _____ Ph #: _____ Relation: _____

My consent will remain in effect as long as I am a patient of Mary Cox, D.O. unless and until I notify Mary Cox, D.O. in writing.

Signature of patient or representative

Date

Print Name

Relation of Representative to Patient

Although allowed under HIPAA, North Carolina law does not permit the release of PHI outside of the hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operation purposes as defined and limited by HIPAA. There is no exception for family members, except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.