AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that information disclosed by this authorization, except for alcohol and substance use disorder information that is subject to 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

I authorize Williamston Hospital Corporation, d/b/a Martin General Hospital (the "Hospital"), to disclose the following information from the medical records of:

Patient Name:_____ Date of Birth:_____

Address:_____

Telephone:_____ Patient Number:_____

Covering the period(s) of health care:

From _____ to _____

From _____ to _____

INFORMATION TO BE DISCLOSED:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)

☐ Complete health record(s), excluding all images

OR

Select from the following (check as many as apply):

☐ Discharge summary
☐ History and physical examination
☐ Consultation reports
☐ Photographs, videotapes, digital or other images
☐ AIDS or HIV infection
☐ Progress notes
☐ X-ray reports
☐ Laboratory tests
☐ Mental health care or services
☐ Treatment for alcohol and/or substance use disorder
☐ Other (please specify)_____

This information is to be disclosed to the following individual or entity for the purpose of:

☐ At request of individual
☐ For long-term care/life/other insurance application
☐ Research
☐ Attorney/legal
☐ School
☐ Disability
☐ Sale
☐ Other (please specify)_____

Name:_____ Date:_____

Address:_____

Telephone:_____

I understand that unless earlier revoked, this authorization will expire one (1) year from the date of my signature unless I specify a different expiration date or event here: _____

I understand that I may revoke this authorization at any time by notifying the Hospital in writing, but if I do, it won't have any effect on any actions the Hospital took before it received my revocation. If this authorization was obtained as a condition of obtaining insurance coverage and I later revoke it, other law may allow the insurer to contest a claim under the policy.

The Hospital, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

_____
Signature of Patient or Representative

_____
Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient: _____
_____

Please complete this form, sign and send via email or fax to: MartinGeneralHospital@sharecare.com or 858-244-3523. A scan or screenshot picture of the signed form is acceptable.