PATIENT AUTHORIZATION / MEDICAL RELEASE FORM

To Permit Use and Disclosure of Health Information

This form implements the requirements for patient authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164. Except as otherwise permitted or required by the privacy law, a health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 C.F.R. §164.508(c).

Patient Name: Date of Birth:
Last four digits on SSN: _____

I am either the patient named above or the patient's legally authorized representative. By signing

this form, I authorize _____ to use or disclose to the
Doctor, hospital or medical facility where treated

New Hanover County District Attorney's Office
316 Princess Street Suite 543
Wilmington, NC 28401

the following protected health information:

Any and all information regarding treatment provided to the above-named individual from

_____ through _____, including, but not limited to, physicians' records, patient
Date *Date*
care notes, ambulance call report narratives, photographs, and all billing information.

The purpose of this disclosure is to aid in the prosecution of criminal charges.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in the treatment provider's Notice of Privacy Practices, a copy of which has been provided to me.

I understand that I may refuse to sign this authorization. I also understand that the treatment provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization.

I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be re-disclosed by the person or agency that receives it.

This authorization expires automatically upon the disposition of the criminal case.

I have read and understand the information in this authorization form.

Signature of Patient/Guardian:_____

Please Print Name:_____ Date:_____