PATIENT AUTHORIZATION

To Permit Use and Disclosure of Protected Health Information

☐ Any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc. or other healthcare provider that has provided treatment or services to me or that has paid for or is seeking payment from me for such services is referred to as the "Covered Entity."

☐ _____ is referred to as the "Covered Entity."

Re: _____ **_____** **_____**

Patient Name **Social Security Number** **Date of Birth**

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize the Covered Entity to use or disclose any and all of my protected health information to the following person(s): _____.

The purpose of the use or disclosure is to help me in my medical care.

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 this Authorization, as well as the exceptions to my right to revoke, will be performed in accordance with applicable federal law and any applicable policy of the Covered Entity.

I understand that I may refuse to sign this Authorization. I also understand that the Covered Entity 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 applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure.

This authorization expires automatically upon 1/01/2050 or two years after my death, whichever is later.

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

Signature of Patient:	
Please print name:	Date:

— OR —

Signature of Authorized Representative:	
Please print name:	Date:
Please explain Representative's authority to act on behalf of the Patient:	
If Representative's authority to act on behalf of the Patient is based on a written document, please attach a copy of such written document to this Authorization.	

STATE OF NORTH CAROLINA)
)
COUNTY OF FORSYTH)

On this _____ day of _____, 20___, before me personally appeared _____, to me known to be the person described in and who signed this Patient Authorization, by reviewing his/her driver's license and witnessing his/her execution hereof, and who acknowledged that he/she signed it voluntarily as his/her free act and deed, with full authority to obtain the requested information under federal and state law.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid, the day and year above written.

My Commission Expires: _____ _____
Notary Public