SAMPSON
REGIONAL MEDICAL CENTER
607 Beaman Street, Clinton, NC
910.592.8511
www.SampsonRMC.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This form is for use when such authorization is required and complies with the HIPPA Privacy Rule (45 CFR §164.500-534) .

Patient:_____ **Date of Birth:**_____

Address:_____ **Telephone:**_____

_____ **Med Rec #:**_____

Release Information From:	**Release Information To:**
_____ (List applicable Facility(s) and/or Practice(s)	_____ (Name of Facility, person, company)
_____	_____ (Street Address or PO Box, City, State, Zip Code)
_____ (Phone number) (Fax number)	_____ (Phone number) (Fax number)

Treatment dates: From:_____ **To:**_____

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care

☐ Insurance ☐ Legal purpose including discussions & proceedings ☐ Other_____

☐ Complete Medical Record
☐ Discharge Summary
☐ Emergency Room Report
☐ History & Physical Exam
☐ Consultation Reports
☐ Operative/Pathology Reports
☐ Progress Notes
☐ Radiology Reports
☐ Laboratory Reports
☐ Cardiology Reports
☐ Physical Therapy Reports

☐ Other (please specify):_____

PATIENT'S RIGHTS– I understand that:

- I can revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance on this authorization.
- This is a full release including information related to behavioral/mental health, treatment for alcohol and/or drug abuse (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others any my information may no longer be protected by federal and state privacy protections (HIPPA privacy standards).
- Refusing to sign this form will not prevent my ability to get treatment (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- Sampson Regional Medical Center, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extend indicated and authorized herein.
- A fee may be charged for providing protected health information.

_____ _____ _____
Patient (Parent/Guardian/Power of Attorney) Signature **Relationship** **Date**

_____ _____
Witness *As a witness, I am witnessing the signature and not the contents of this document **Date**

OVER FOR FEE INFORMATION

SAMPSON
REGIONAL MEDICAL CENTER
607 Beaman Street, Clinton, NC
910.592.8511
www.SampsonRMC.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Medical Records Fee Information

GENERAL STATUTES OF NORTH CAROLINA
CHAPTER 90 — MEDICINE AND ALLIED OCCUPATION
ARTICLE 29 — MEDICAL RECORDS / SECTION 90.411 — RECORD COPY FEE

A healthcare provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be:

- 75 cents per page for the first 25 pages,
- 50 cents per page for 26 through 100, and
- 25 cents per page for each page in excess of 100 pages.

The healthcare provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs.

_____	_____	_____
Patient (Parent/Guardian/Power of Attorney) Signature	**Relationship**	**Date**