COMPREHENSIVE EPILEPSY PROGRAM
PATIENT CARE • EDUCATION • RESEARCH

EPILEPSY INSTITUTE OF NORTH CAROLINA
THE BRAIN IS WHERE YOU LIVE

Authorization to Release Health Information

Patient Name: _____ DOB:_____/_____/_____

I authorize the release of the requested information below:

- ☐ LABS ☐ TESTING ☐ THERAPY ☐ OTHER
- ☐ PROGRESS / NURSE NOTES ☐ PSYCHOLOGY NOTES
- ☐ PSYCHIATRY NOTES ☐ PERSON TO PERSON CONTACT (eg phone calls)

I authorize release of information FROM:	**I authorize release of information TO:**
Name of person and/or facility which has information	Name of person and/or facility which has information
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone number	Phone number
Fax number	Fax number

Please specify the health information you authorize to be released:

☐ **MEDICAL** ☐ **MENTAL HEALTH** (other than psychotherapy notes)

AUTHORIZATION FOR TREATMENT

My signature below indicates my consent for treatment as prescribed by the EPILEPSY INSTITUTE OF NORTH CAROLINA:

_____ _____
Signature Date*
(Patient, Parent, Responsible Party, or Personal Representative)

I understand that my treatment will not be conditioned on signing this Authorization and that I have the right to refuse to sign this Authorization. I understand that information disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law.

You may also authorize the release of information for treatment provided after the date of the signature on this Authorization as long as such treatment occurs while this Authorization has not expired. Please initial if you would like this Authorization to release information about health care you receive after the date of your signature.

_____ Initial here

REVISED 12/5/2015

The following information will NOT be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R §§ 2.34 and 2.35).
- ☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g).
- ☐ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j).

The purpose of this release is for (check one or more of the following):

- ☐ At the request of the patient/patient representative
- ☐ Other(state reason) _____

NOTICE

Epilepsy Institute of North Carolina and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may NOT be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, (4) to create health information to provide to a third party.

I understand that I have a right to revoke this authorization by sending written notification. I understand that I have the right to inspect or copy the protected health information as described in this document. **I also understand that the *Epilepsy Institute of North Carolina* may deny the request.**

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of my signing this form.

_____ _____

Signature (Patient, Parent, Responsible Party, or Personal Representative)

Date

REVISED 12/5/2015