10208 Cerny Street - Suite 308 | Raleigh, NC 27617 | P 919-797-0550 | F 919-381-4621

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (HIPAA)

Instructions: Sentinel Primary Care is HIPAA compliant. We take seriously our legal obligation to protect confidential patient information. We give all patients the opportunity to read our HIPAA Notice of Privacy Practices (NPP) and ask for their written acknowledgment. Please help us maintain our respect for patient privacy and comply with the law by completing this authorization form giving us permission to discuss patient information with specific individuals such as spouses, other adults, children, etc.

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I have had the opportunity to read Sentinel Primary Care's HIPAA Notice of Privacy Practices regarding the Use and Disclosure of Protected Health Information (PHI). I understand that I may refuse to sign this authorization to release PHI and that my refusal to sign will in no way affect my treatment, payment, enrollment in a health plan, or eligibility for benefits. I also understand that my signature is required in order to complete this request.

Sentinel Primary Care may use and disclose either all of my PHI or specific components of my PHI as specified below only for the specific purpose identified below and for the time period specified below or until the completion of the event for which I have provided the authorization. My authorization is not a blanket permission to use and disclose PHI.

At all times, I retain the right to revoke this authorization to use and disclose PHI. Should I wish to exercise this right, I will submit a written request to the Sentinel Primary Care Practice Administrator.

I understand that the party that receives my PHI may re-use or re-disclose the information received. At that point, the PHI may no longer be protected under federal or state confidentiality rules.

I understand that Sentinel Primary Care may charge a fee for copying the medical records for which I have provided authorization for use and disclosure.

I have read the information related to use and disclosure and understand that I may request a copy of this form if desired.

Medical Record Number: (to be filled in by practice) _____

Patient Name: _____

Date of Birth: _____ / _____ / _____

Address: _____

Telephone: Home _____ Cell _____ Work _____

SENTINEL PRIMARY CARE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (HIPAA)

As the patient or the individual authorized to act on behalf of the patient, I authorize the use and disclosure of the following protected health information (PHI) relating to me as described below.

I, (NAME)_____, hereby authorize Sentinel Primary Care to release the following information:

____ Office Notes ____ Mental Health

____ Entire Chart ____ Drug and alcohol addiction

____ Pathology Report ____ HIV

____ Lab test results ____ Other: _____

Release information to: (name and relationship to patient)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Purpose for Release: _____

Time Period: (e.g. calendar year 20XX; upcoming hospitalization, etc) _____

Signature of Patient or of Individual Authorized to Act on Patient's Behalf:

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian Printed Name