Adult Campus
3019 Falstaff Road, Raleigh, NC 27610
Phone: 919-250-7000 Fax: 919-250-7075

Holly Hill HOSPITAL

Children's Campus
201 Michael J. Smith Lane, Raleigh, NC 27610
Phone: 919-250-7600 Fax: 919-250-6709

Authorization to Use or Disclose Protected Health Information

(Patient/Resident Name) (Date of Birth) (SS#) (Dates of Treatment)

I hereby freely and voluntarily authorize Holly Hill Hospital to...

____ Release/disclose my protected health information to:
____ Obtain my protected health information from:

(Individual, Facility or Organization) (Phone Number)

(Address) (Fax Number)

(City, State, Zip Code)

The purpose of this disclosure is for:

___ insurance purposes ___ educational placement ___ legal reasons ___ medical treatment
___ discharge planning ___ continued treatment ___ the patient ___ progress updates
___ other (explain) _____

Information to be used or disclosed:

___ Discharge summary ___ Psychiatric Evaluation ___ Lab/X-ray results ___ Progress report (verbal)
___ Psychological testing ___ Medication records ___ Physician's orders ___ Comprehensive assessment
___ Psycho-social assessment ___ Medical consultation ___ History & physical ___ IQ test results
___ Aftercare plan ___ Other (explain) _____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Holly Hill Hospital's Privacy Officer, except to the extent that action has already been taken in reliance on it. This authorization will expire 180 days (X) following discharge, or ( ) following signature unless another date or condition is specified. Other date or condition specified: _____

*Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(Patient/Resident – when applicable by law or hospital policy) (Date)

(Guardian or Representative) (Date) (Relationship to Patient/Resident)

☐ Parent/Guardian unavailable to be reached to review

Verbal consent by Patient/Legal Guardian physically unable to provide a signature

By signing below, I witness that the Patient/Legal Guardian is physically unable to provide a signature but that he/she understands the nature of this Authorization and freely gives his/her verbal consent to disclose the information as described.

(Witness 1 - signature) (print) (Date)

(Witness 2 - signature) (print) (Date)

Released by (Hospital staff) (Date)