

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)**

**This authorization is for use or disclosure of protected health information**

**Name:** -----

**Address:** -----

**Phone#:** -----

**I hereby authorize the following health care provider:**

Name: \_\_\_\_\_

Address: -----

Fax#: -----

Phone#: -----

**To release my protected health information to:**

Roanoke Chowan Community Health Center

120 Health Center Drive, Ahoskie NC 27910

Phone Number 1-252-332-2548

Fax# 1-833-813-3471

**Purpose of disclosure:**

- Changing Physicians  Continuing Care  At my (patient) request  Workers' Compensation  Legal  
 Second Opinion  Insurance  School  Other -----

**Protected health information to be released:**

- Medical records (specify, can state "all"): \_\_\_\_\_  
 Billing records  DX-ray report  Consultation report  Other \_\_\_\_\_  
Time frame:  entire record  records from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

**Your specific permission is required to disclose information regarding the following:**

***Check box and sign to specify protected health information to be disclosed***

- Treatment by Mental Health Professional or Program \_\_\_\_\_

*[Note to practice: this includes records generated at a mental health agency/facility or by a psychiatrist, clinical nurse specialist, social worker or psychologist; records created by other physicians do not require specific authorization]*

- Drug/Alcohol Abuse \_\_\_\_\_

*[Note to practice: this includes records generated by medical personnel whose primary function is providing alcohol or drug abuse diagnosis, treatment, or referral and who are identified as such providers, not general care providers]*

- HIV Test Results or Status -----