

**CRAVEN REGIONAL  
MEDICAL CENTER  
NEW BERN, N. C.**

**AUTHORIZATION FOR RELEASE/DISCLOSURE OF PROTECTED HEALTH  
INFORMATION TO ANOTHER ENTITY FROM CRMC                      PAGE 1 OF 2**

I hereby authorize the release or disclosure of my individually identifiable health information as described below, I understand that this authorization is voluntary. By signing this Authorization, I understand that I am giving my Authorization to Craven Regional Medical Center ("CRMC") to disclose my protected health information ("PHI") as specified in this Authorization. I further understand that if the person or organization I authorize to receive the information is not a health care provider or health plan, the released information may no longer be protected by federal or state privacy regulations.

I authorize Craven Regional Medical Center to disclose the following information from the medical records of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Patient Medical Record Number: \_\_\_\_\_

Covering the period (s) of health care:

From \_\_\_\_\_ to \_\_\_\_\_; From \_\_\_\_\_ to \_\_\_\_\_

Information to be disclosed:

- Complete health record (s) \*, including all images (X-rays, CT Scan, MRI, Ultrasound, Nuclear Medicine, Mammograms, photographs, etc.)
- Complete health records (s)\*, excluding all images
- Include records from providers other than CRMC (contained in CRMC's records)  
\* Includes any communicable disease, drug and alcohol records and mental health records, except Psychotherapy Notes, for which a separate authorization must be signed.

**OR**

Select from the following (check as many as apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Progress Notes        |
| <input type="checkbox"/> History and Physical Examination  | <input type="checkbox"/> Laboratory Tests      |
| <input type="checkbox"/> Consultation Reports  | <input type="checkbox"/> X-ray/Imaging Reports |
| <input type="checkbox"/> Treatment for alcohol and/or drug abuse   | <input type="checkbox"/> Billing Records       |
| <input type="checkbox"/> Mental health care or services (does not include Psychotherapy Notes for which a separate authorization must be signed) |  |
| <input type="checkbox"/> Photographs, videotapes, X-rays, CT Scan, MRI, Ultrasound, Nuclear Medicine, Mammograms, digital and other images       |  |
| <input type="checkbox"/> Other (please specify) _____  |  |
| _____  |  |
| _____  |  |

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The purpose of the disclosure is:

- Claim or suit for personal injury. CRMC reserves its rights to a provider lien under N.C.G.S. § 44-49.
  
- Other. Please Specify \_\_\_\_\_  
\_\_\_\_\_

This information is to be disclosed to the following individual or Entity:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

The patient or the patient's representative must read and initial the following statements:

- a. I understand that unless earlier revoked that this authorization will expire within six months of signing or on the happening of \_\_\_\_\_ if sooner. Initials: \_\_\_\_\_
  
- b. I understand that I may revoke this authorization at any time by notifying CRMC in writing, but if I do it will not have any effect on any actions CRMC took before it received the revocation. Initials: \_\_\_\_\_
  
- c. I understand that CRMC cannot make me sign this authorization as a condition to receive treatment from CRMC except:
  - (i) when CRMC provides me with research-related treatment in which I have agreed to participate; or
  - (ii) when I have asked CRMC to provide me with health care solely for the purpose of creating protected health information for disclosure to someone else, such as my employer. Initials: \_\_\_\_\_

CRMC, its employees, officers, and physicians involved in my care are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

***(Form MUST be completed before signing)***

Signature of Patient or Representative	Date
Print Name	Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient.

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**\*YOU MAY REFUSE TO SIGN THIS AUTHROIZATION \***