Onslow Memorial Hospital
P.O. Box 1358, 317 Western Boulevard
Jacksonville, NC 28541-1358
Telephone: (910) 577-2454 / 2641
Office Hours Mon- Fri 8-4.30

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Crist Clinic

OMH and its business associates understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. **Mail the completed form, along with a copy of your ID to validate and protect your identity to Health Information Management Dept, Onslow Memorial Hospital, POB 1358, 317 Western Blvd Jacksonville, NC 28541-1358.**

Section A: Release of Protected Health Information			
Patient Information:	**First**	**Middle**	**Last** Any Former Name(s)
	Telephone Number	Social Security Number	**Date of Birth**
To Whom Medical Information May be Released:	**Name**		
Address:	**Address to where records should be mailed**		
Specific Document(s) Needed:	**Crist Clinic Records**		
Specific Department(s):	**Crist Clinic Records**		
Purpose:	Continuity of Medical Care		

Period of Treatment:	From _____ To _____
Expiration Date/Event of Authorization:	❒ 30 Days ❒ 60 Days ❒ 90 Days ❒ Other (explain):

* An abstract may include the following: discharge summary, history & physical, consults, operative reports, pathology reports, laboratory reports, radiology reports, special tests, and Emergency Department records.

Section B: Specific Understanding

1.	I, or my personal representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.
2.	I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.
3.	I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, OMH cannot honor my request to disclose my medical and/or billing information.
4.	I understand that if my medical and/or billing records contain information relating to **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check and initial the box on the front of this form.
5.	I understand that I have the right to request to inspect and/or receive a copy of the information described on this authorization form. I also understand that I have a right to receive a copy of this form after I have signed it.
6.	I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that the hospital has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage. To revoke this authorization, please put your request in writing and send to OMH Medical Records.

Patient Understanding and Signature

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

*** Note: Once the information requested in this form has been released to the authorized "Person or Organization", Onslow Memorial Hospital and/or Diversified Information Technologies can no longer be responsible for its security.**

_____ _____

Signature of Patient or Personal Representative **Printed Name of Patient or Personal Representative**

_____ _____

Date **Description of Personal Representative's Authority**

Office Use Only

Form of Identification:	❒ Drivers License ❒ State ID ❒ Military ID ❒ Other_____
Request Filled By:	
Notes:	