



**INCOMING TO MAHEC**

**MAHEC Family Health Center  
Centralized Medical Records Department**

123 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 | Fax: (828) 407-2637

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**COMPLETE ALL SECTIONS, DATE, AND SIGN**

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

I authorize the use or disclosure of the above named individual's health information as described below.

<b>The information is to be disclosed by:</b>	<b>And is to be provided to:</b>
NAME OF FACILITY:	Family Health Center at: <input type="checkbox"/> Biltmore <input type="checkbox"/> Newbridge <input type="checkbox"/> Deerfield <input type="checkbox"/> Cane Creek <input type="checkbox"/> Enka/Candler <input type="checkbox"/> Givens
ADDRESS:	<b>123 Hendersonville Road</b>
CITY/STATE:	<b>Asheville, NC 28803</b>
PHONE #: _____ FAX #: _____	

**The purpose or need for this disclosure is:**

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

**Information to be disclosed:** (check appropriate box(es))

- Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- Only information related to (specify): \_\_\_\_\_
- Only the period of events from: \_\_\_\_\_ to \_\_\_\_\_
- Entire medical record
- Exclusions
  - \_\_\_ AIDS/HIV test results, diagnosis, treatment, and related information
  - \_\_\_ Drug screen results and information about drug and alcohol use and treatments
  - \_\_\_ Mental health notes
  - \_\_\_ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. \_\_\_\_\_

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

**By signing below, I acknowledge that I have read and understand this Authorization.**

<b>SIGNATURE OF PATIENT</b>	DATE
<b>SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE (State relationship to Patient)</b>	DATE
<b>WITNESS TO SIGNATURE, IF APPLICABLE</b>	DATE

*YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.*