Authorization to Request Protected Health or Billing Information

Patient Name: _____ Patient Address: _____

Nickname/Maiden Name/Alias: _____ _____

Phone #: _____ _____

Date of Birth: _____ Medical Record Number: _____

I give permission to:

_____
(Name of Facility/Person)

_____
(Address)

_____
(City, State, Zip)

To share my health information with:

MATTHEWS SURGERY CENTER
710 PARK CENTER DRIVE, SUITE 100
MATTHEWS, NC 28105

FAX (704) 815-7878
PHONE (704) 815-7880

Check information to be shared:

- ☐ Name
- ☐ Address
- ☐ Phone Number
- ☐ Insurance
- ☐ Social Security #
- ☐ Entire Medical Record
- ☐ Other: _____
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Radiology Images
- ☐ Consultation
- ☐ Physician Dictation
- ☐ Billing information
- ☐ Nurses Notes
- ☐ Surgery Report
- ☐ Medication Records
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Test Results

Treatment Dates (must be a specific date or range of dates) _____

Important Notice: This is a full release, including drug, alcohol, psychiatric and sexually transmitted disease information unless listed here: _____

Check reason to share health information: ☐ My (patient) request ☐ Legal ☐ Workers' compensation ☐ Disability ☐ Treatment: ☐ Insurance Other (Describe) _____

Share Information: ☐ In Person ☐ Pick up ☐ Fax ☐ Mail ☐ Other (Describe) _____

1. By law Matthews Surgery Center cannot use or share my health information without my permission, except by ways listed in Matthews Surgery Center Notice of Privacy Practices.
2. I can cancel this permission at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel the sharing of information already given as a result of this permission.
3. I do not have to sign this form. Refusal will not change my ability to get treatment, payment for treatment or benefits.
4. Once information is sent, it may not be protected by law. Someone may be able to share my information with others without my permission.
5. I have read, understand and, upon my request, been given a copy of this form.
6. This is not for use for Marketing or Research.

NOTICE: There may be a fee charged to make copies of my medical record.

My permission ends 90 days after the date I signed, unless a date or event is written here: _____

_____ _____ _____
Patient/Patient Representative Signature Date Time

Legal Authority to sign for patient: ☐ Healthcare agent ☐ Guardian ☐ Attorney in Fact ☐ Parent ☐ Next of Kin ☐ Administrator/Executor

If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.

Patient is: ☐ Minor ☐ Disabled ☐ Deceased ☐ Incompetent ☐ Incapacitated

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted _____ ☐ Interpreter refused
(Name/number of person/services chosen/used)

MATTHEWS SURGERY CENTER

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