LINCOLN COMMUNITY HEALTH CENTER, INC.

1301 Fayetteville St. - Durham, NC 27707
P.O. BOX 52119 ● ZIP: 27717-2119
(919) 956-4000 Fax (919) 687-4257

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

FACILITY LOCATION:
Lincoln Community Health Center1301 Fayetteville St, Durham NC 27707
Durham Recovery Response 309 Crutchfield St, Durham NC 27704
Early Intervention Clinic 414 East Main St., Durham, NC 27701
Durham County Human Services-Family Medicine: 414 East Main St., Durham, NC 27701
Healthcare for the Homeless Clinic 412 Liberty St, Durham, NC 27701
Hillside Wellness Center 3727 Fayetteville St., Durham, NC 27707
Holton Clinic 401 N. Driver St, Suite 1106, Durham, NC
Lyon Park Clinic 1313 Halley St, Suite 137, Durham, NC 27707
Walltown Clinic 815 Broad St, Durham, NC 27705
Live Well 3901 N. Roxboro Rd, Suite 105., Durham, NC 27704

PATIENT INFORMATION:

NAME: _____
Last *First* *Middle*

DATE OF BIRTH: _____ LCHC#/MRN: _____

I, the undersigned, hereby authorize the disclosure of the following confidential records/information:

Records/Information From:

_____
Name of Facility Producing Records

_____
Street Address

_____
City, State, Zip

Send Records Information To:

_____
Person/Agency

_____
Street Address

_____
City, State, Zip

_____
( ) Phone Number ( ) Fax Number

____**Reciprocal Authorization** for Release of Information (check if applicable/authorizing): this authorization allows Lincoln Community Health Center to have continuous dialogue between clinical personnel of Lincoln Community Health Center and the entity identified above. This authorizes full disclosure of the patient's medical records, psychotherapy notes, recommendations for further care, and names of health care personnel, dates of hospitalizations, charges, and visits. All records are kept confidential and shared only with pertinent personnel involved. I understand that this Reciprocal Authorization expires one-year (365 days) from the date it is signed by patient/legal guardian.

Type of Record(s) Information to be disclosed: Please circle all that apply
ڤAny and All ڤSpecific Record(s)/Info: (1) Clinic Notes (2) Health Assessment (3) OB Records
(4) Referral Request (5) Consultation (6) Medication List
(7) TB/PPD (8) Pathology Report (9) Immunization Record
(10) Lab Reports/Results (11) X-Ray Reports (12) Specialty Clinics
(13) Statement of charges& payments (list dates) (14) Other: _____

Dates of Treatment/Information to be disclosed: From: _____ To: _____

How you would like the Protected Health Information to be disclosed: mail ڤ fax ڤ pick up/walk in

SENSITIVE INFORMATION: Records pertaining to the treatment of psychiatric/mental health; alcohol/substance abuse; and HIV/AIDS treatment are covered under specific federal and state confidentiality laws. Re-disclosure of each of these types of records is prohibited without the specific written authorization of the person to whom the treatment pertains or as otherwise permitted by these laws. By initialing below, I hereby give consent to have the following sensitive information disclosed:

	Initials	Treatment Date(s)
Psychiatric/Mental Health Records/Information	_____	_____
Alcohol/Substance Treatment Records/Information	_____	_____
HIV Results/AIDS Treatment Records/Information	_____	_____
Other Communicable Diseases	_____	_____
Adolescent Confidential	_____	_____

Type of Record(s) Information to be disclosed:
ڤAny and All ڤSpecific Record(s)/Info: _____

PURPOSE OF THE DISCLOSURE OF INFORMATION:

( ) Legal/Attorney ( ) Insurance ( ) Continuing Care ( ) SSI/SSA
( ) Personal Use ( ) Second Opinion ( ) DSS ( ) Disability Determination
( ) Investigation ( ) Change Provider/Relocation ( ) Research ( ) Other _____

This disclosure shall become valid immediately and shall remain in effect for the following period:

Initials (You must initial one of the following for the request to become valid)

_____This authorization expires once information is disclosed. This is a one-time disclosure.
_____This authorization expires as specified: _____
_____This authorization is valid until such request is fulfilled, but not to exceed ninety (90) days.
_____This authorization expires at the end of research study.

My authorization is given freely with the understanding that:

1. I may refuse to sign this authorization. I understand that this information cannot be disclosed unless it is signed.
2. I may revoke this authorization at any time by providing a written revocation to Lincoln Community Health Center, unless an insurance company requires this authorization as a condition of obtaining insurance coverage. My revocation will not apply to information Lincoln Community Health Center may have already disclosed in reliance on this authorization.
3. There will be a charge for a personal copy of my records as permitted by State or Federal law. MRO Corporation has been contracted to provide this service. For questions, call 1-888-252-4146.A photocopy or fax of this authorization is as valid as the original.
4. I understand that the potential exists for information disclosed pursuant to this authorization to be re-disclosed by the recipient and at that time, may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA).
5. Lincoln Community Health Center may not condition my treatment on my provision of this authorization.
6. This authorization is valid only for the time period specified above. Lincoln Community Health Center, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
7. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health record.
8. I will be given a copy of this signed authorization if the authorization is at the request of Lincoln Community Health Center.

PRINTED NAME: _____

SIGNATURE_____DATE:_____

RELATIONSHIP (Choose one): ف Patient ف Parent ف Guardian ف Representative ف Conservator ف Other: _____

Description of Legal authority to act on behalf of patient: _____

ADDRESS:_____TELEPHONE # (___)_____

❑ **Copy of Power of Attorney attached** **Copy of Power of Attorney attached** **___Copy of Court Order attached (includes custody document)**

ACKNOWLEDGEMENT OF RECEIPT: To be completed by the patient, the patient's personal representative or other person designated in the authorization to receive the requested protected health information when the patient, representative or other person appears at Lincoln Community Health Center in person to receive the information.

I hereby acknowledge that I have received the above requested health information:

PRINTED NAME: _____

SIGNATURE:_____DATE: _____

ADDRESS:_____TELEPHONE # (__)_____

Office Use Only

_____
SIGNATURE