West Caldwell Health Council, Inc.

Collettsville Medical Center
Old Highway 90 / PO Drawer 9
Collettsville, NC 28611
Tel: (828) 754-2409
Fax: (828) 754-2418

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Happy Valley Medical Center
Highway 268 / PO Box 319
Patterson, NC 28661
Tel: (828) 754-6850
Fax: (828) 757-3214

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

I authorize West Caldwell health Council, Inc., to disclose or request information from the medical records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Covering the period of healthcare: From _____ to _____

Information to be disclosed or request: ☐ Complete health record(s)
☐ All images (x-rays, etc.)
☐ Pertinent hospital records

AND/OR:_____

Purpose for information to be received from or disclosed to the following individual or entity:

☐ Referral ☐ Other: _____

Individual or entity to receive or disclose information:

Name: _____ Relationship: _____

Address: _____ Phone: _____

a. I understand that unless earlier revoked, this authorization will expire upon termination as a patient at WCHC, Inc. I understand I may revoke this authorization at any time by notifying West Caldwell Health Council, Inc. in writing, but if I do, it will not affect any actions taken before the written revocation is received.

b. I understand that WCHC, Inc cannot make me sign this authorization as a condition to receive treatment, except when WCHC, Inc. provides me with research related treatment or when healthcare is solely provided for the purpose of creating protected health information for disclosure to someone else.

Print Name: _____ Relationship to Patient: _____

_____ _____
Signature of Patient or Representative Date