

OFFICE USE LAST NAME: _____ DOB: ____ / ____ / ____ CHART: _____

**Eastern Carolina Internal Medicine, PA
HIPAA PRIVACY**

**AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION TO
FAMILY MEMBERS/CAREGIVERS/FRIENDS**

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and the regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

By signing this authorization, the patient is providing Eastern Carolina Internal Medicine, PA, with the appropriate authorization to discuss the patient's healthcare and payment of that healthcare with family members, caregivers and/or friends. This authorization has all of the information completed to allow Eastern Carolina Internal Medicine, PA, to communicate with the people you choose by completing this form. *If you would like to be more specific about the information we release to your family members, please complete the general authorization form with the specifics completed on that form.* This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Eastern Carolina Internal Medicine, PA, will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**

By signing this authorization you acknowledge and agree that Eastern Carolina Internal Medicine, PA may use or disclose Protected Health Information (which may include but it not limited to: lab results, radiology results, medical records, hospital notes, etc...). This authorization extends to information on the use of alcohol, drugs, and tobacco; the diagnosis and treatment of HIV infection or other sexually transmitted diseases; and the diagnosis and treatment of mental illness.

By signing this authorization you agree that Eastern Carolina Internal Medicine, PA or its Business Associates may disclose your personal health care information to the following person(s):

Full Name (printed)	Date of Birth	Relationship
_____	___ / ___ / ___	_____
_____	___ / ___ / ___	_____
_____	___ / ___ / ___	_____
_____	___ / ___ / ___	_____

By signing this authorization, you agree that Eastern Carolina Internal Medicine, PA or its Business Associates may disclose your personal health care information for the purposes of treatment, continuity of care and payment for that treatment.

Expiration Date (circle one): None -or- Specific (indicate expiration date) ____/____/____

Further, by signing this authorization, you acknowledge that you have been provided a copy of and understand Eastern Carolina Internal Medicine, PA's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. The Privacy Notice is available to you on our company

website; www.ecim.com. While Eastern Carolina Internal Medicine, PA has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Eastern Carolina Internal Medicine, PA at any of its offices or by sending a written request (including return address) to the following address: Privacy Officer, PO Box 68, Pollocksville, NC 28573.

In Accordance with your rights under and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI in the designated record set maintained by Eastern Carolina Internal Medicine, PA for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time except to the extent that Eastern Carolina Internal Medicine, PA, has taken action in reliance on it. A revocation is effective upon receipt by Eastern Carolina Internal Medicine, PA of a written request to revoke, and a copy of the executed authorization form to be revoked at the address listed above (Privacy Officer).

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

At patient's request, Eastern Carolina Internal Medicine, PA will provide a copy of this signed authorization.

Acknowledged and agreed to by the following:

PATIENT

_____/_____/_____
Signature **Date**

_____/_____/_____
Full Printed Name (print) **Date of Birth**

-or-

ON BEHALF OF PATIENT

_____/_____/_____
Signature **Date**

Full Name (print) **As**

_____/_____/_____
Patient's Date of Birth