



New Hanover County

Health Department

2029 South 17th Street

Wilmington, NC 28401-4946

Phone 910/798-6763

FAX 910/772-7805



Last Name First Name M.I.

Patient Social Security # - _____/_____/_____
(Optional)

Date of Birth _____/_____/_____

1. I hereby authorize _____

to release the specified information in the patient record of:

to the following: _____

2. The nature and extent of the information includes: _____

3. This information will be used for: _____

4. *The following information shall be excluded and shall not be released* _____

I understand the terms of this release, the need for the information, and that there are statutes and regulations protecting the confidentiality of information. I acknowledge that this consent is voluntary and is valid until such request is fulfilled. I further understand that I may revoke my consent by giving written notices to the agency with the authority to release the information, except to the extent that action based on this consent has already been taken. ***I understand that the New Hanover County Health Department may release all information included in the patient record, unless specifically excluded in Item 4 above. This includes information received from other providers. Psychotherapy notes may not be released, with a few exceptions, unless specifically authorized on a separate Release of Information form.***

/s/Witness

/s/Patient, Parent, or Legally Appointed Representative
(Circle appropriate title)

Date, event or condition of expiration

Date signed

Request for record access denied due to
(You may request to speak with a supervisor about this decision.)

Date

Signature (Staff)

Note: This Authorization was revoked on _____
Date

Signature (Staff)