NORTH CAROLINA DEPARTMENT OF CORRECTION
AUTHORIZATION FOR RELEASE OF INFORMATION

DEPARTMENT OF CORRECTION NOTICE to the Requestor of Information: The documents attached contain health information regarding a current or former inmate. Based on NC State Laws and NC Department of Correction Policies and Procedures, the information may be discussed with the inmate, but copies of the information may not be given directly to the inmate or family members.

Complete All Lines on this Authorization.

PRINT Information

Name: _____ Inmate Number: _____

D.O.B.: _____ S.S.#: _____

I authorize **NC Department of Correction - Pat Tinsley**
Name of Facility Releasing Information

831 W. Morgan St.
Address

Raleigh NC, 27699-4278
City, State, Zip Code

919-838-3885
Phone Number

919-715-9534
Fax Number

to release information from my medical record to

_____ _____
Name of Facility/Person Receiving Information *Phone Number*

_____ _____
Address *Fax Number*

_____
City, State, Zip Code

This information shall include _____
Specify the information you wish to be disclosed

_____

for the purpose of _____
Need for disclosure

I understand this information pertains to the time period of _____
Dates of Treatment

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time by signing the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment; however, if a service is requested by a non-treatment provider for the sole purpose of creating health information, service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____ _____
Signature of Patient *Date* *Authorized Representative* *Date*

_____ _____ _____
Witness Signature -When required (see back)* *Date* *Relationship to Patient of Authorized Representative*

DOP Use Only: Information released by _____ on _____
Print Name *Date Information Released*

File: Outpatient, Section II / Inpatient
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This form is not to be amended, revised or altered without approval of the Medical Records Committee.

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REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____ (Patient Name)

_____ (Patient Number) signed by _____ (Name of person who signed authorization) on _____ (Date of signature)

be rescinded, effective _____ (Date). I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ (Signature of Patient) _____ (Date) _____ (Authorized Representative) _____ (Date)

_____ (Witness Signature - When required*) _____ (Date) _____ (Relationship to Patient of Authorized Representative)

* Witness Signature required when:
- The inmate/patient is illiterate or physically unable to sign their name and signs with an "X" mark. NC Statues and HIPAA do not require a witness in any other situation.

* Proof of signing authority is required when:
- The inmate/patient has been declared incompetent by the courts. The guardian or person authorized by the court to act in the patient's behalf signs on the "Authorized Representative" line. Attach a copy of the court papers to the authorization.
- A person holding Healthcare Power of Attorney who has been given authority to make health care decisions. Healthcare Power of Attorney signs on the "Authorized Representative" line. Attach a copy of the papers to the authorization.
- The inmate/patient is deceased. The executor or administrator of the estate, or the next of kin, signs on the "Authorized Representative" line. Attach a copy of the papers to the authorization. The executor, administrator, or next of kin shall not have personal access to the patient medical record.