

\_\_\_\_\_  
Last Name            First Name    MI

Patient SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

NC Department of Health and Human Services  
Public Health Nursing

**PATIENT AUTHORIZATION  
to Permit Use and Disclosure of  
Health Information**

I am either the patient named above or the patient's legally authorized representative.

By signing this form, I authorize Onslow County Health Department  
[1] *Person or class of persons authorized to use or disclose the information*  
to use or disclose to \_\_\_\_\_  
[2] *Person or class of persons to whom use or disclosure would be made*  
the following protected health information (*identify the information in a specific and meaningful fashion*):

\_\_\_\_\_  
The purpose of the use or disclosure is [3] (*describe each purpose of the requested use or disclosure*):  
\_\_\_\_\_  
\_\_\_\_\_

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in

Onslow County Health Department 's  
[4] *Name of covered entity*  
Notice of Privacy Practices, a copy of which has been provided to me.

I understand that I may refuse to sign this authorization. I also understand that  
Onslow County Health Department  
[4] *Name of covered entity*  
cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization. [5]

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon 1 Year from date of Signature

[6] *Date or event that relates to the patient or the purpose of the use or disclosure*

\_\_\_\_\_  
*Signature of patient OR authorized representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please print name of patient or authorized representative who signed above*

[7] *Please explain representative's authority to act on behalf of the patient:* \_\_\_\_\_