Please check the box to the left of the appropriate facility / Marque la casilla a la izquierda del centro correspondiente:

- ☐ Brody School of Medicine at East Carolina University
- ☐ East Carolina Endoscopy Center
- ☐ ECU Health Beaufort Hospital - A Campus of ECU Health Medical Center
- ☐ ECU Health Bertie Hospital
- ☐ ECU Health Chowan Hospital
- ☐ ECU Health Duplin Hospital
- ☐ ECU Health Edgecombe Hospital
- ☐ ECU Health Home Health & Hospice
- ☐ ECU Health Medical Center
- ☐ ECU Health North Hospital
- ☐ ECU Health Physicians
- ☐ ECU Health Roanoke-Chowan Hospital
- ☐ The Outer Banks Hospital
- ☐ Vidant SurgiCenter
- ☐ Other / Otro _____

ECU HEALTH

Behavioral Health Authorization & Consent for Release of Protected Health Information (PHI)

PLEASE PRINT

Patient's Name: _____
First *Middle* *Last*

Social Security Number: _____ Date of Birth: _____
Last 4 Digits *Month* *Date* *Full 4 – Digit Year*

I authorize ☐ ECU Health _____ Behavioral Health to exchange information with:
Entity Name

Individual: _____ ☐ Family: _____
Relationship

Agency: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

☐ Employer ☐ EAP
☐ Aftercare ☐ Physician
☐ Therapist ☐ Referral Source
☐ Other: _____

For The Purpose of: ☐ Diagnosis, Treatment & Discharge Planning, Continuity of Care, **OR** ☐ _____ *(Be Specific)*

To Be RELEASED	To Be OBTAINED
Dates of Service _____ **to** _____	**Dates of Service** _____ **to** _____
(INSERT DATES OF SERVICE FOR INFORMATION TO BE RELEASED)	*(INSERT DATES OF SERVICE FOR INFORMATION TO BE RELEASED)*
☐ Psychiatric History & Physical/Evaluation/Assessment	☐ Psychiatric History & Physical/Evaluation/Assessment
☐ History & Physical	☐ History & Physical
☐ Physician's Orders	☐ Physician's Orders
☐ Nursing & Psychosocial Assessments	☐ Nursing & Psychosocial Assessments
☐ Progress Notes	☐ Progress Notes
☐ Psychological/ Neuropsychological Evaluation	☐ Psychological/ Neuropsychological Evaluation
☐ Medications	☐ Laboratory, X-ray, & Diagnostic Studies
☐ Drug/Alcohol Abuse (if applicable)	☐ Drug/Alcohol Abuse (if applicable)
☐ FL – 2	☐ HIV/AIDS/ARC (if applicable)
☐ Treatment Plan / Plan of Care & Reviews	☐ Treatment Plan / Plan of Care & Reviews
☐ Discharge Summary	☐ Discharge Summary
☐ Verbal Communication Regarding:	☐ Verbal Communication Regarding:
☐ Other:	☐ Other:

NOTICE TO PARTIES RECEIVING DRUG/ALCOHOL ABUSE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient except as set forth in the Federal rules.

PROHIBITION ON RE-DISCLOSURE: This information is confidential and protected by Federal and State Law. Any further redistribution is strictly prohibited unless specific written consent of the patient for the re-disclosure of this information is obtained. This authorization is subject to patient revocation at any time except to the extent that action has already been taken.

If not previously revoked, this consent will expire (check one): ☐ 30 days after discharge **OR** ☐ Other: _____

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I also understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by written notification. I understand that my revocation or modification of this authorization will not affect any actions taken by the hospital in reliance on this authorization before it receives my request for revocation or modification. I must sign my written request and send it to **ECU Health**.

_____ _____ _____ _____
Patient/Representative Signature ***Patient/Representative PRINTED Name*** ***Date*** ***Time***

Check one: ☐ Patient ☐ Guardian ☐ Power of Attorney ☐ Other: _____
Specify Date or Event

_____ _____ _____ _____
Witness Signature ***Witness PRINTED Name*** ***Date*** ***Time***

3247/EH-068