AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION UNDER FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I hereby authorize the use or disclosure of my individually identifiable health information as described below to be used in the course of official N.C. Department of Labor – Occupational Safety and Health Division investigations. I understand that this Authorization is voluntary. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Patient Name: _____ SSN: _____ DOB: _____

Patient Address: _____
Street Address City State Zip

Persons/Organizations Providing the Information: _____
Medical Provider Name/Practice Name

Persons/Organizations Receiving the Information: N.C. Department of Labor – Occupational Safety and Health Division
Department/Division Name

_____
Principal OSH Investigator Name

_____
Mailing Address

_____
City State Zip

_____ _____
Phone Number E-Mail Address

Specific Description of Information, Covering Health Care From: _____ to _____
Start Date End Date

☐ Complete Health Records, Excluding Bills (e.g., first responder reports, history and physical, diagnostic test results and reports, laboratory results, operative reports, consultation reports, discharge summary, photographs)

☐ Other (Please Specify): _____

The patient or the patient's representative must read and initial ALL of the following statements:

1. I understand that this Authorization will expire on: _____ Initials: _____
2. I understand that I may revoke this Authorization at any time by notifying the providing organization in writing and that, if I do revoke this Authorization, this will not have any affect on any action the providing organization takes before receiving the revocation. Initials: _____
3. I understand that I have the right to refuse to sign this Authorization. Initials: _____
4. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure, and the privacy of the information will no longer be protected under federal medical privacy law. However, pursuant to the N.C. Department of Labor – Occupational Safety and Health Division's administrative rules regarding access to employee medical records (13 NCAC 07A, Section .0900), the information disclosed pursuant to this Authorization is not subject to disclosure to the public. Initials: _____

I have read and understand the information in this Authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

FORM MUST BE COMPLETED IN ITS ENTIRETY

3/21/2011