N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION INSTRUCTIONS

PURPOSE

To protect individually identifying health information maintained by the Division of Services for the Blind (DSB). No Department of Health and Human Services (DHHS) agency shall disclose or be required to disclose, in individually identifiable format, information about an individual without that individual's explicit authorization, unless for specifically enumerated purposes such as emergency treatment, public health, law enforcement, audit/oversight purposes or unless state for federal law allows specific disclosures.

PREPARED BY

DSB Staff

1. The form should be filled out entirely and signed by the individual. If the individual signs with blanks on any line, the document is considered invalid.
2. The information to be released should be specific and there should be a date when the authorization expires.
3. Correction fluid, mark through, or any effort to change a document cannot be used to correct an error. If mistakes are made on the form, start over with a new form.
4. Both pages of the form should be included and not just the first page.

An Authorization to Disclose information will be an invalid authorization if it has any of the following deficiencies:

1. The expiration date has passed or the expiration event has been known to occur.
2. The document is not filled out completely.
3. The document does not contain the core elements of an authorization.
4. The authorization is known to have been revoked.
5. Any information recorded on the authorization is known to be false.
6. An authorization for disclosure of psychotherapy notes is combined with another request for disclosure of information other than psychotherapy notes.

Refer to the DHHS policy link for further guidance.
http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/Use_and_Disclosure_Authorizations.pdf

INSTRUCTIONS

Client Name: Enter individual's name (first name, middle initial and last name).

Date of Birth: Enter a two-digit month, two-digit day and four-digit year for the date the individual was born. (Example: July 17, 1960 would be entered as 07/17/1960)

Client Medical Record #: Enter the individual's medical record number at the facility/provider of services where the health information originated.

Client SS# (optional): Enter individual's nine-digit Social Security Number.

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I _____ : Enter the name of the individual or his/her duly authorized Personal Representative. If the Personal Representative signs the authorization form, a description of such authority to act for the individual must also be documented on the form.

Hereby authorize: Enter the specific detailed name of the entity owning the medical records. This could be an eye care practitioner's office, a hospital, an insurance company, etc.

To disclose specific health information from the records of the above named client to: Enter the detailed name and other information relating to the entity that is to receive the health information.

For the specific purpose(s): Enter the specific reason the health information is needed (examples: to provide medical information so decisions can be made about services authorized/payment of invoices or to determine eligibility for services).

Specific information to be disclosed: Enter a detailed explanation of information needed and why it is needed (example: an eye report from a specific date is needed to pay on outstanding invoice or to determine eligibility).

I understand that this authorization will expire on the following date, event or condition: Enter the two-digit month, two-digit day and four-digit year this authorization will expire.

Individual should either read the statements on the authorization or the interviewer should read them to him/her. If the individual or personal representative is unable to sign his/her name, an “X” or other mark/ symbol is acceptable instead of a signature as long as it is witnessed and documented, attesting to the validity of the signature.

If a witness is required, that person signs the form.

Personal Representative signs and dates the form.

Personal Representative identifies the relationship or authority with the individual.

NOTE: This authorization was revoked on: Enter the two-digit month, two-digit day and four-digit year for the revocation date.

DSB Staff person who witnessed the revocation signs the form

DISTRIBUTION

Original: Entity information is being requested

Copy: Case Record
Individual

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION REVOCATION SECTION INSTRUCTIONS

PURPOSE

To rescind in writing an Authorization to Disclose Health Information due to the request of the individual.

PREPARED BY

DSB Staff

INSTRUCTIONS

I do hereby request that this authorization to disclose health information of: Enter individual's name (first name, middle initial and last name).

Signed by: Enter name of the person that signed the original authorization (first name, middle initial and last name).

On: Enter the two-digit month, two-digit day and four-digit year that the original signature document was effective.

Be rescinded, effective: Enter the two-digit month, two-digit day and four-digit year that the original document will be rescinded.

Individual signs and dates the form.

Witness signs and dates the form.

Personal Representative signs and dates the form.

Personal Representative identifies the relationship or authority with the individual.

DISTRIBUTION

Original:	Case Record
Copy:	Individual

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION VERBAL REVOCATION SECTION INSTRUCTIONS

PURPOSE

To rescind verbally an Authorization to Disclose Health Information due to request of the individual

PREPARED BY

DSB Staff

INSTRUCTIONS

I do hereby attest to the verbal request for revocation of this authorization by: Enter individual's name (first name, middle initial and last name).

On: Enter the two-digit month, two-digit day and four-digit year that the original signature document will be verbally rescinded.

DSB Staff person signs and dates the form.

Witness signs and dates the form.

DISTRIBUTION

Original: Case Record
Copy: Individual