Stanly Health Services

Authorization by Individual for SHS to Obtain PHI from Another Person or Entity

I authorize the disclosure of my protected health information (PHI) to Stanly Health Services (SHS), as follows:

BY: _____
identify or name entity, person(s) or class of persons authorized to disclose PHI to Medical Center

WHAT: _____
specific description of the Individual's protected health information to be disclosed

FOR: _____

_____
description of each purpose of the requested disclosure

Unless earlier revoked, this authorization will expire 180 days from today unless checked otherwise below:

☐ expiration date: _____, 200_____ ; or

☐ event, or condition: _____

I acknowledge that I understand that I may refuse to sign this Authorization and that treatment, payment, enrollment in any health plan, or eligibility for benefits are *not* conditioned upon the signing of this Authorization. However, SHS may condition the provision of any research-related treatment on the signing of this Authorization. At all times, I understand that I retain the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be in writing and submitted to the SHS Privacy Officer in person or by certified mail. The revocation shall be effective *except* to the extent that SHS has already used or disclosed information in reliance on the Authorization. I have been informed and understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information; and, at that point, the information may no longer be protected under the terms of this Authorization.

I have read and understand this information. I am the Individual or am authorized to act on behalf of the Individual and sign authorizing the use or disclosure of my protected health information under the above terms. I have received a copy of this form.

_____ _____ _____
Individual or Representative Signature Date Time

_____ _____
Print Name Witness

_____
Relationship of Representative to Individual

Please Describe the Representative's Authority to Act on Behalf of the Individual:

_____
(Attach a Copy of Any Documentation of Representative's Authority)

HIPAA Form VI.E.1.02

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