HIPAA Privacy Authorization Form

Hampstead Family Medicine
144 Merchants Circle
Hampstead, NC 28443
Phone: 910-803-0340

Burgaw Medical Center
311 South McNeil Street
Burgaw, NC 28425
Phone: 910-259-3377

Patient Name: ______________________________________ **DOB:** ______________________

I, __________________________ hereby authorize Hampstead Family Medicine/ Burgaw Medical Center to release my Protected Health Information (PHI) to the following people listed:

Name: __________________________ **Relationship:** __________________ **DOB:** _________

Name: __________________________ **Relationship:** __________________ **DOB:** _________

Name: __________________________ **Relationship:** __________________ **DOB:** _________

Name: __________________________ **Relationship:** __________________ **DOB:** _________

Name: __________________________ **Relationship:** __________________ **DOB:** _________

(Required by the Health Insurance Portability and Accountability Act- 45 CFR Parts 106 & 164)

- By signing this you are authorizing the release of your complete health record which may include mental health, communicable diseases requiring special care and/or treatment or alcohol and/or drug abuse.
- This authorization will include all past, present, and future periods.
- This authorization will remain in effect unless authorize is changed in writing.

Patient Signature: ____________________________ **Date:** ______________________________