

# CONSENT WAIVER AND RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, do hereby authorize and request \_\_\_\_\_ to disclose to \_\_\_\_\_ records as specified below, and containing my identity, diagnosis, prognosis, or treatment from the approximate period of \_\_\_\_\_ to \_\_\_\_\_.

Specific information to be disclosed includes:

- |                                |                         |                          |
|--------------------------------|-------------------------|--------------------------|
| DATA will be released _____    | DISCHARGE SUMMARY _____ | HISTORY & PHYSICAL _____ |
| in written verbal, audio _____ | OPERATIVE REPORTS _____ | PATHOLOGY REPORT _____   |
| video electronic form _____    | RADIOLOGY REPORTS _____ | LAB REPORTS _____        |
| _____                          | EKG _____               | EMERGENCY ROOM/OP _____  |
| _____                          | AUTOPSY REPORT _____    | OTHER(SPECIFY) _____     |

I hereby request and authorize the above-named agency organization or individual which possesses information relative to the patient named above to release information, as specified, to the agency, organization or individual named on this request. I understand that the information to be released may include information regarding drug abuse, infectious disease, alcohol abuse, sickle cell anemia, or psychological or psychiatric impairments.

Furthermore, I, \_\_\_\_\_, do hereby give permission to Pitt County Memorial Hospital/East Carolina University to prepare, use, reproduce, publish, exhibit, my name, picture, portrait, likeness, or voice, or any or all of them for use by the news media, the university and hospital in their public relations and educational programs. Any photograph, photo transparency, drawing or other illustrative graphic material, audio-visual tape or audio-visual illustration may be used without my prior examination of the finished product.

I have crossed out, dated and initialed any exceptions to this Consent Waiver and Release of Medical Information form.

I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be redisclosed without my further written consent unless otherwise provide for by state or federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire:

- \_\_\_\_\_ upon satisfaction of the need for disclosure;
- \_\_\_\_\_ within \_\_\_\_\_ 90 \_\_\_\_\_ days from the date signed,
- \_\_\_\_\_ under the following condition: \_\_\_\_\_

Furthermore, I hereby waive my rights to privacy in connection with consent given and I hereby release, discharge, and agree to hold harmless all the parties to whom this consent is given from any liability whatsoever and agree that this consent and waiver will not be made the basis of a future claim of any kind.

**PLEASE RETURN INFORMATION REQUESTED BY PITT COUNTY MEMORIAL HOSPITAL TO:**

Release of Information, Medical Record Services  
 Pitt County Memorial Hospital 252-847-4799 - Phone  
 P.O. Box 6028 252-847-8169 - Fax  
 Greenville, North Carolina 27835

DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.

WITNESS' SIGNATURE \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

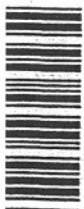
PARENT/LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PCMH MR #: \_\_\_\_\_



184/2270