



North Carolina Department of Health and Human Services  
 Division of Public Health • Epidemiology Section  
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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Client Scan Form Number # \_\_\_\_\_ Client SS # \_\_\_\_\_

I \_\_\_\_\_ hereby authorize  
 (Client or Personal Representative)

HIV/STD Prevention and Care Branch Staff to disclose to UNC, Dr. Christopher Pilcher and associates on the STAT Referral Network and the \_\_\_\_\_ Case Management agency the following protected health information: **HIV test results and follow-up information.** I understand that this release will allow other STAT Team members contact me in the future for follow-up.

I understand that this authorization will automatically expire one year from today's date or: \_\_\_\_\_ I understand that if I fail to specify another expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time and that to do so, I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that my record contains information relating to HIV infection, AIDS or AIDS-related conditions, and may contain information relating to alcohol abuse or drug abuse and this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I will be given a copy of this signed authorization.

\_\_\_\_\_  
 (Signature of Client) (Date) (Witness)

\_\_\_\_\_  
 (Signature of Personal Representative) (Date) (Personal Representative Relationship/Authority)

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NOTE: This Authorization was revoked on \_\_\_\_\_  
 (Date) (Signature of Staff)



## REVOCATION SECTION

I do hereby request that this authorization to disclose health information of \_\_\_\_\_

*(Name of Client)*

signed by \_\_\_\_\_ on \_\_\_\_\_

*(Enter Name of Person Who Signed Authorization)*

*(Enter Date of Signature)*

be rescinded, effective \_\_\_\_\_.

*(Date)*

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

\_\_\_\_\_  
*(Signature of Client)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Signature of Witness)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Signature of Personal Representative)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Personal Representative Relationship/Authority)*