Cape Fear HealthNet
Bridging the Gap for the Uninsured

1601 Doctors Circle
Wilmington, NC 28401
Phone: (910) 399-2751
Fax: (910) 399-2756

Partners: Cape Fear Clinic, Good Shepherd Center, MedNorth Health Center, New Hope Clinic and WHAT

Patient Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____

Authorization for Use and Disclosure of Protected Health Information

1. **Disclosure Authorized.** I authorize all of my health care providers, health plans, and case management service providers, including physicians, nurses, hospitals, nursing homes, the Medicaid program, private health insurers, Community Care of the Lower Cape Fear and all other persons and entities who have provided, or may be providing me with any type of health care, health insurance or case management services, to disclose all of my protected health information to Cape Fear HealthNet ("CFHN"), and its partners: Cape Fear Clinic, Good Shepherd Center, MedNorth Health Center, New Hope Clinic and Wilmington Health Access for Teens (WHAT) with the exception of psychotherapy notes.

I further authorize CFHN and partners to share any protected health care information it obtains from the above health care providers, health plans, health insurers and case management service providers to other health care providers, health plans, health insurers, and case management service providers and to all other persons and entities who may be contacted for a health care referral, and also to appropriate social service agencies. I also authorize CFHN and partners to verify financial information with appropriate service providers and any current or previous employers as is necessary to complete eligibility verification.

CFHN staff or partner may also discuss my case with the following persons:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

CFHN or partner staff may leave a message on my answering machine/voice mail at home: Y / N
CFHN or partner staff may leave a message on my answering machine/voice mail at work: Y / N
CFHN or partner staff may leave a message with someone or on the answering machine/voice mail at my emergency contact number: Y / N

2. **Purpose of Authorization.** The purpose of this authorization is to enable Cape Fear HealthNet and partners to assist me in managing my medical condition and connect me with other community resources, partners and medical providers, for services which I might need.

3. **Expiration Date.** This authorization will expire one (1) year from the above date unless revoked by me prior to that date. This authorization may be revoked by me in writing at any time.

4. **Required Disclosures.** I understand that any information used or disclosed under this authorization may be subject to re-disclosure and may no longer be protected under federal privacy rules.

I understand that my health care providers and health benefit plans cannot refuse to treat me or deny me benefits simply because I refuse to sign this authorization.

_____ _____/_____/_____
Patient Signature Date
Print Name: _____

_____ _____/_____/_____
Person Signing on Behalf of Patient Date
Print Name: _____

_____ ____/_____/_____
Witness Signature Date
Print Name: _____