



707 Murchison Road, Suite 3
Fayetteville, NC 28301
(P) 910.483.6869 (F) 910.483.5898
chnnc.org

Authorization for Use and Disclosure of Protected Health Information

(page 1 of 2)

Patient Name: _____ Date: _____

Date of Birth: _____

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, Carolina Collaborative Community Care, Inc. (4C) 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 Cumberland HealthNET (CHN).

I further authorize CHN 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 health care referral, and also to the persons listed below. I also authorize CHN to verify financial information with these agencies and any current or previous employers as is necessary to complete eligibility verification.

CHN staff may also discuss my case with the following persons:

Name	Relationship	Phone number

CHN staff may leave a message on my answering machine/voice mail at home: Yes No

CHN staff may leave a message on my answering machine/voice mail at work: Yes No

CHN staff may leave a message with someone or on the answering machine/voice mail at my emergency contact number:
 Yes No

Purpose of Authorization. The purpose of this authorization is to enable Cumberland HealthNET to assist me in managing my medical condition and connect me with other community resources, including medical providers, for services which I might need.

Expiration Date. This authorization will expire five (5) years from the above date unless revoked by me prior to that date. This authorization may be revoked by me in writing at any time.

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



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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

Printed Name: _____

Signature of Legally Responsible Person

Date

Printed Name: _____

Witness Signature

Date

Printed Name: _____

Please mail or fax this document to a CHN Enrollment Specialist:

Address: 707 Murchison Road, Suite 3 | Fayetteville, NC 28301

Phone: (910) 483-6869 | Fax (910) 483-6869