Authorization & Consent for

ECU HEALTH

Release of Protected Health Information (PHI)

SECTION A: Who is requesting authorization?

Jennifer "Beth" Cartrette
Name of patient

N/A
Prior name(s), if any

136 Creek View Lane
Street Address

XXX-XX- 7 9 8 5
Social Security Number *(Last 4 digits only)*

Wingate
City

(704) 960-9336
Area Code and Telephone Number

North Carolina 28174
State Zip Code

09/13/1982
Date of Birth

SECTION B: Who will provide this information? (*ECU Health Entity, Address & Phone*)

Gregory L. Duncan, PhD
Department of Psychiatry & Behavioral Medicine
ECU-OPC/905 John Hopkins Drive
(252) 744-1406 duncang@ecu.edu

SECTION C: Who will receive this information?

Name/Dept.: Self - Jennifer Beth Cartrette

Address: 136 Creek View Lane
Wingate, NC 28174

SECTION D: How will information be sent/received?

☒ Mail to address in *Section C* ☐ Pick Up

☐ MyChart. If you have given MyChart proxy access to others, your proxy(ies) will not be able to view the information unless you list here proxies you want to be able to view it:_____

☐ Email: _____

☐ Other: _____

The risks of electronic transmission of PHI have been discussed.

SECTION E: Describe the purpose for the request.

☐ Attorney/Legal ☒ Continued Care

☐ Personal Use ☐ Insurance

☐ Other: _____

SECTION F: Describe the specific Protected Health Information to be used or disclosed, including date(s):

☒ Psychotherapy Notes for date(s) ADHD and Learning Disability Assessement and Reports ***If this box is checked, a separate authorization form must be completed in order to authorize release of any other type of protected health information (phi).***

☐ Entire Treatment Record		Date(s):
☐ Billing Statements	I have an adult autism assesment scheduled soon	Date(s):
☐ Laboratory Reports		Date(s):
☐ Diagnostic Images (X-ray, etc.)		Date(s):
☒ Other (Describe): ADHD, Learning Disability		Date(s): ≈ 2005 - 2006

SECTION G: By signing below I indicate my understanding that:

- This authorization is voluntary. Treatment or payment will not be affected if I do not sign this form, except as provided by law.
- This is a full release including information related to HIV/AIDS, psychiatric care and/or psychological assessment, and alcohol and/or drug abuse treatment (in compliance with 42 CFR Part 2).
- Information may be re-disclosed by the recipient, in which case it may no longer be protected under federal and state privacy protections.
- I may revoke this authorization at any time by notifying in writing the entity listed in Section B. If I do revoke this authorization, the revocation won't have any effect on any release or disclosure that has already been made.

SECTION H: Expiration and Revocation

This authorization will expire (check one): ☒ On (enter date): July 1, 2025 ***OR*** ☐ (Enter event or date): _____

SECTION I: Signature

I hereby authorize the use or disclosure of the Protected Health Information (PHI) as described above.

Jennifer Beth Cartrette
Signature of patient ***OR*** patient's Personal Representative

June 26, 2024
Date

13:00
Time

Signature of individual releasing requested PHI

Print Name of individual releasing PHI

SECTION J: If Section I is signed by a Personal Representative, please complete the information below:

Print Representative's Name: _____ Relationship to Patient: _____

Signature of Person Verifying Representative's Authority: _____

Print Name of Person Verifying Representative's Authority: _____

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