New Hanover Regional Medical Center

New Hanover Regional Medical Center
Patient Financial Services
PO Box 9000
Wilmington, NC 28402-9000
Telephone: (910) 667-6234

*** Required Fields**

AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

Section A:* Must be completed for all authorizations

PATIENT IDENTIFICATION: First | Middle | Maiden/Former | Last

Account Number

Date of Birth

Social Security # XXX-XX-

Phone #

Medical Record #

SPECIFIC INFORMATION NEEDED:

- NHRMC Financial Aid Application (which may include proof of income, pay stubs, W2, tax returns, and/or letter of support)

☐ Other (specify)

PURPOSE:* Disclosure of this information is needed for potential coordination or management of health care.

AUTHORIZATION:* I authorize and request NHRMC to release financial information that aligns with the NHRMC Financial Aid Application to Cape Fear HealthNet within 30 days of a complete application being received.

Section B: Must be completed only if a health plan or a health care provider has requested this authorization

I understand that Cape Fear HealthNet will not receive financial or in-kind compensation in exchange for using or disclosing the financial information described above. **Initials***

Section C:* Must be completed for all authorizations

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials***

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I will be given a copy of this authorization form, after signing. **Initials***

Section D:* Must be completed for all authorizations

I hereby authorize the use or disclosure of my financial information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying the Patient Financial Services Department in writing and that this will automatically expire 6 months from the date signed below.

This hereby releases the sender from all legal responsibility or liability of the release of information described above from the records.

I also understand that if I revoke my authorization it will not have any effect on any actions NHRMC took before it received the revocation. I understand that financial information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

Printed Name:* (Patient or Authorized Representative)

Date:*

Signature:* (Patient or Authorized Representative)*

Witness:*

(Relationship if other than Patient)*

Form of identification* ☐ Drivers License ☐ State issued ID ☐ Military ID ☐ Other

PLEASE SEND THIS INFORMATION TO CAPE FEAR HEALTHNET

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

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