

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

I, _____ authorize the following information to be released by

(Name of Entity/Address/Phone Number)

Entire Record
Office Notes

Laboratory Reports
Radiology Reports

Other: _____

Purpose of disclosure:

Change of Doctor
Legal Investigation
Personal
Insurance

Disability Determination
Continuing Care
Workers Comp

Other: _____

Entity or person who will receive the information:

Name _____

Address _____

City, State, Zip _____ Phone _____

This authorization is valid for 12 months from the date of signature. Please allow a minimum of five (5) business days to complete the request.

Patient Rights:

- I have the right at any time to revoke this authorization.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal or state law.
- I may refuse to sign this authorization, my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis..

Signature of Individual or Guardian or
Personal Representative of Patient's Estate

Date

Description of Guardian or Personal Representative

There is a charge for medical records when requested for personal reasons. Questions may be directed to 919-330-1940.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-919-330-1940.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-919-330-1940。