

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 | Laboratory Reports | Other: _____ |
| Office Notes | Radiology Reports | |

Purpose of disclosure:

| | | |
|---------------------|--------------------------|--------------|
| Change of Doctor | Disability Determination | Other: _____ |
| Legal Investigation | Continuing Care | |
| Personal Insurance | Workers Comp | |

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.