AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MEDCENTER 1
1688 East Arlington Boulevard
Greenville, North Carolina 27858
Phone (252) 353-1464
Fax (252)353-1272

Date: _____

Patient Name: _____

Address: _____

_____

Date of Birth: _____

Social Security # : _____

I authorize _____to release to _____ my medical records as designated by my initials below. I consent to have my records, including any labs faxed to the aforestated. Please initial all applicable below:

_____ Office notes
_____ All specialist notes (if applicable)
_____ Diagnostic tests (including the faxing of my labs/x-rays/special diagnostic scans)
_____ HIV results
_____ Psychiatric information
_____ Substance abuse information

I do not have to sign this authorization in order to receive treatment from Med Center 1. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Purpose of disclosure _____

Expiration Date _____

Patient Sign : _____

Witness: _____