AUTHORIZATION TO RELEASE HEALTH INFORMATION TO A HEALTHCARE PROVIDER

Patient information:
Name Of Patient: _____ Date of Birth:_____
Street/Mailing Address: _____
City, State, Zip: _____

Name & Address of Covered Entity authorized to release information:

_____
_____
_____
_____

Forward Information To:

_____
_____
_____
_____

The information below will be used for patient care. (Description of PHI needed)

Progress note: _____ Admission H & P: _____
Lab Data: _____ Discharge summary: _____
Diagnostic Testing: _____
Other:

_____
_____

This authorization shall be in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:
I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to:

Anthony Medical Clinic, PA
311 W. Third Avenue
Gastonia, NC 28052

Signature of patient: _____ **Date:** _____

Description of Personal Representative's Authority:_____