



AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Release of Information Form)

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #: _____

I hereby authorize the use or disclosure of my individual identifiable health information as described below. This includes information pertinent to mental health, drug/alcohol abuse and HIV/AIDS diagnosis. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization. I understand that if the organization authorized to receive the information is not a health plan or a healthcare provider, the released information may no longer be protected by federal or state privacy regulations.

I authorize **Laurel Creek Family Medicine**: 900 Old Winston Road, Suite 222
Kernersville, NC 27284
Phone: (336) 992-1234 Fax: (336) 993-9963

TO RELEASE INFORMATION TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

TO OBTAIN INFORMATION FROM:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released/disclosed (Select from the following. Check as many as apply):

- | | |
|---|--|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Progress/office notes |
| <input type="checkbox"/> History & physical | <input type="checkbox"/> Laboratory tests |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> Operative notes | <input type="checkbox"/> Other: _____ |

I understand that this authorization will expire on ____/____/____.

There may be a charge for re-production of medical records

Signature of Patient

Date

Signature of Parent/Guardian/Authorized Representative

Date

Witness Signature

Date