Authorization for Disclosure of Health Information

I hereby authorize _____ **to release medical information from the records of:**
(Name of Facility)

Patient Name: _____ **D.O.B.:** ___/___/_____ **SS#:** _____-___-_____

Patient Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date(s) of Treatment Requested: _____

Information to be disclosed (check all applicable items to be released):

- ☐ Discharge Summary
- ☐ Discharge Instructions
- ☐ History and Physical
- ☐ Consultations
- ☐ Operative Report
- ☐ ER Record
- ☐ X-Rays Reports
- ☐ Lab Reports
- ☐ EKG/ECG Tests
- ☐ Therapy Notes
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Doctor's Orders
- ☐ Nurse's Notes
- ☐ Treatment Plans
- ☐ Commitment Papers
- ☐ HIV testing
- ☐ Other (please specify): _____

Purpose Or Need For The Disclosure Is:

☒ Continued Medical Care ☐ Insurance ☐ Legal ☐ Patient's Own Use ☐ Other _____

The Information May Be Disclosed To:

Recipient's Name: Internal Medicine Associates: Dr Jan Harrison & Dr. Esther Poza

Street Address: 105 NEWSOM STREET, SUITE 106

City: DURHAM **State:** NC **Zip Code:** 27704

Phone #: (919) 471-5800 **Fax #:** (919) 471-5801

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ **or upon the following event:** _____
(Date)
(If no date or event is specified, this authorization will expire in six months from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

_____ _____
(Signature of Patient or Personal Representative)* *(Date of Signature)*

***If signed by a personal representative, a description of the representative's authority to act is as follows:**

☐ **Parent** ☐ **Legal Guardian** ☐ **Health Care Power of Attorney**
☐ **Administrator** ☐ **Executor of Estate** ☐ **Next of Kin** ☐ **Beneficiary**

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