albemarle endocrinology

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AUTHORIZATION FOR RELEASE OF INFORMATION

_____20_____

I_____ **authorize** _____ **to release the information**
(Name) **(Facility/Hospital name)**

below to_____ **at the following address:**

_____

☐ Discharge Summary ☐ History and Physical Exam ☐ Laboratory Report ☐ Radiology Report
☐ Path Report ☐ ER Report ☐ Consultation Report ☐ Operative Report
☐ Entire Record ☐ Billing & Payment History ☐ Other _____

Dates of Service: _____

Patient Name: _____

Date of Birth: _____ **Social Security Number (optional):** _____

Phone Number H:_(_____)_____ **W:**_(_____)_____

Purpose of request: ☐ Personal use ☐ Continuing Care ☐ Other _____

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential health care records to include if applicable, **PSYCHIATRIC, DRUG/ALCOHOL OR HIV TESTING/TREATMENT** records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have the right to revoke this authorization. My authorization will not be effective until it is delivered in writing to the Health Information Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or another person, or when revocation is not permitted by law.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that treatment, payment, or eligibility for benefits cannot be conditioned on me signing this form unless it is for the sole purpose of obtaining information for a research study. A copy of this authorization will be included with my original records.

Special Instructions: _____ (none if blank)

_____ _____
Signature of Patient or Legal Representative Date
Legal representative, indicate relationship to patient_____
☐ Identification verified _____
Requesting Unit/Department

This Authorization is only valid for the information/
Purpose(s) indicated above, and **expires 180 days (6 months)** from signature date unless otherwise indicated on this authorization.