AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FORM

Purpose of Release: __ ongoing communication _X_ copy of record _X_ legal or insurance review

__ authorized representative request __ other ______________________________________

Release From: The facility/practice/individual listed below is authorized to release the requested health information:

Facility/Practice Name: ____ Telephone # __________________

Facility/Practice Address: ____ Fax # ____________________

Dates of Service Range of Time or Event(s): The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or event(s):
From: (MM/DD/YY) ____________________________________ To: (MM/DD/YY) ____
This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.

Check The Specific Information To Be Released:
_X_ All Records & Details __ Other (Please Specify) ____
I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex and/or human immunodeficiency virus (HIV).

Name of Patient Whose Information Is To Be Released:
Patient Name: ____________________________ ___________________________ ____
First Middle/Maiden Last
Patient Address: ____
(Street Address / PO Box, City, State, Zip)
Social Security #:____________________________Date of Birth:__________________ Medical Record / Chart #:_____________
Please provide phone numbers where you are authorizing to leave patient information as described above:
Home: ___________________________ Work: ______________________________ Cell: _________________________________

Release To: This information may be released to and used by the following individuals / organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals / organizations listed below:

Name	Address	Telephone/Fax #	Relationship
Wright Law Firm of Charlotte, PLLC	**525 N. Tryon Street, Suite 1600 Charlotte, NC 28202**	**(704) 332-2274 / (704) 333-5424**	**Attorney**

Patients Rights And Signature:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed in the Notice of Privacy Practices / Policy.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.

If the patient is a minor or is clinically unable to sign, an authorized representative my sign this authorization.
PRINT NAME (Patient/Authorized Representative): ____

SIGNATURE: ____ DATE: _________________________
IF Authorized Representative, please indicate relationship to patient: __ Spouse __ Parent __ Guardian __ Executor of Estate __ __ Power of Attorney

Minors Signature: Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.
NAME OF MINOR: ___________________________ SIGNATURE OF MINOR: ______________________________________
DATE: ___________