PATIENT CENTERED CARE, PLLC
AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize _____ to disclose the following information from the medical records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Patient Number: _____

Covering the period(s) of health care:
From _____ to _____

Information to be disclosed: Patient Centered Care PLLC fax 910-799-6261

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
OR
Select from the following (check as many as apply):

- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ X-ray reports
- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
- ☐ Mental health care or services
- ☐ Psychotherapy Notes
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Photographs, videotapes, digital or other images

☐ Other (please specify) _____
_____

This information is to be disclosed to the following individual or entity for the purpose of: ___
_Transfer/ Transition of Care_____
_____

Name:__Patient Centered Care__PLLC_____ Relationship: _Primary Care Provider_____

Address: __1221 Floral Parkway Unit 105 Wilmington, NC 28409_____

Telephone: _office 910-7499-6262 fax 910-799-6261_____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or in one year.
Initials: _____

b. I understand that I may revoke this authorization at any time by notifying Patient Centered Care in writing, but if I do it won't have any effect on any actions Patient Centered Care took before it received the revocation. Initials: _____

c. I understand that Patient Centered Care, PLLC cannot make me sign this authorization as a condition to receive treatment from Patient Centered Care, PLLC except:

(i) when Patient Centered Care, PLLC provides me with research-related treatment; or

(ii) when Patient Centered Care, PLLC provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
Initials: _____

Patient Centered Care, PLLC its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(*Form MUST be completed before signing*)

_____
Signature of Patient or Representative

_____
Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____

_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION