

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use of disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulation, including HIPPA. I release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

The following individual/organization is authorized to release the requested health information: **Name:** _____

Dates of service being requested: From: _____ To: _____

The following is a list of specific information being requested:

- | | | |
|--|---|---|
| <input checked="" type="checkbox"/> Admission history and physical | <input checked="" type="checkbox"/> Lab reports | <input checked="" type="checkbox"/> Progress notes |
| <input checked="" type="checkbox"/> Anesthesiology records | <input checked="" type="checkbox"/> Medication records | <input checked="" type="checkbox"/> Radiology reports |
| <input checked="" type="checkbox"/> Consultation notes | <input checked="" type="checkbox"/> Nurse's notes | <input checked="" type="checkbox"/> Rehabilitation |
| <input checked="" type="checkbox"/> Discharge summary | <input checked="" type="checkbox"/> Office visit notes | <input checked="" type="checkbox"/> Surgery records |
| <input checked="" type="checkbox"/> EMS report | <input checked="" type="checkbox"/> Outpatient records | <input checked="" type="checkbox"/> Vital signs |
| <input checked="" type="checkbox"/> ER notes and records | <input checked="" type="checkbox"/> Pathology reports | |
| <input checked="" type="checkbox"/> Itemized statement for services rendered | <input checked="" type="checkbox"/> Physicians' orders | |
| | <input checked="" type="checkbox"/> P.T. and O.T. records | |

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

This information may be disclosed to and used by the following individual or organization:

Name: Moser, Garner and Bruner, P.A. **Telephone:** (910) 276-2631
Address: Post Office Box 1827, Laurinburg, NC 28353 **Fax:** (910) 276-0326

Purpose of disclosure: Legal Review Insurance Review Other

I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with a right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign the authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

I understand any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. **I understand that any photocopy of this document will be considered as valid as an original.** Unless otherwise revoked, this authorization will expire on the following date, event or condition: upon conclusion of Moser, Garner and Bruner, P.A. representation. **If I fail to specify an expiration date, event or condition, this authorization will expire in one year.**

Signature: _____ **Witness:** _____

Printed Name: _____ **Date:** _____
(Patient/Authorized Representative)

Address: _____ **Date of Birth:** _____

If Authorized Representative, please indicate relationship to patient: Spouse Parent Other