FAYETTEVILLE Woman's CARE, P.A.

2029 Valley Gate Dr; Fayetteville, NC 28304 Ph: 910.323.2103 Fax: 910.323.2219

Authorization to Disclose Protected Health Information

Patient information: I give permission to release the health information of:

Patient Name_____ **Date of Birth**_____

Street Address _____**Last 4 numbers of SSN**:_____

City, State, Zip_____**Phone**_____

Email address_____

Although Fayetteville Woman's Care will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release information from:

Name_____

Address_____

Phone/Fax_____

Release Information to:

Name_____

Address_____

Phone/Fax_____

Purpose of release (check reason) __Personal __ Insurance __Disability __Workers Compensation __Legal reasons

___Other:_____

Must fill in dates of treatment for records to be released From: _____ To:_____

Office/ Clinic(Check all that may apply)

__office/clinic abstract __ office visits __Consultation reports __Diagnostic tests results

__Laboratory reports __Radiology reports __ Medications __ Billing Information __Other_____

___Entire record unless exclusions are given. Exclusions_____

Format(select one)__Paper copy __Electronic__ CD Delivery Method __ Reg. US Mail __Pick up__ Email __ Fax

I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- A fee may be charged for providing the protected health information.
- I have the right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless another date or event is written here_____

Signature_____ Print name _____Date/time_____