Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

I authorize the practice below to release my health information:

Conner Family Health Clinic
211 W. Matthews Street, Suite #102
Matthews, NC 28105
Phone: 704-708-4301 **Fax:** 704-708-4389

Please forward/release my health information to:

_____

_____

_____

_____

The information below is requested by this patient.
(Check Box: Patient Medical Information Needed)

❒ Entire Record **Past Records:** ❒ 1 year ❒ 2 years ❒ 3 years

❒ Radiology reports ❒ Lab results ❒ EKG

❒ Hospital /Discharge Summary ❒ Other _____

This authorization shall be in effect until the information has been forwarded as requested.

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Conner Family Health Clinic.

_____Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Revised January 2020