PLEASE RETURN FORM:
BY MAIL TO OFFICE (PO Box 5247, Cary, NC 27512) OR E-MAIL to cbaruizmd@gmail.com

Authorization to Release Information from Cleo Baruiz, MD PA

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.

Patient Name:

Patient Date of Birth:

Person or Organization Receiving Records:

Fax to:

Email to: (emailed records will be encrypted)

Telephone:

Records Requested, check one:

- ☐ Last two years, (no charge; free)
- ☐ Other time periods on a case by case basis, charges will apply

Purpose of the disclosure: I understand that this authorization will expire on ______ **(date)** or one year from the date it is signed, whichever is earlier. **Initials:**

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received. **Initials:**

I understand that I am authorizing the release of substance abuse, AIDS, HIV, or other communicable diseases, if such information is present in my record. **Initials:**

____

Signature of Patient or Patient's Representative (form MUST be completed before signing)

Date

Printed Name of Patient's Representative

Patient's Representative Relationship to Patient