**VERBAL/WRITTEN RELEASE OF PROTECTED HEALTH INFORMATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DO HEREBY AUTHORIZE

**SANDHILLS INTERNAL MEDICINE** TO GIVE PROTECTED HEALTH INFORMATION TO

THE FOLLOWING PEOPLE:

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTACT NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INFORMATION THAT MAY BE GIVEN**:

DIAGNOSES, VITAL SIGNS, RESULTS OF LABS AND IMAGING,

CONCERNS REGARDING YOUR HEALTH AND SAFETY AND OTHER PERTINENT INFORMATION

I UNDERSTAND THAT THIS NOTICE WILL BE IN EFFECT FOR 18MONTHS FROM THE DATE I HAVE SIGNED THIS FORM.

I UNDERSTAND THAT I MUST SUBMIT MY REQUEST TO CANCEL THIS AUTHORIZATION IN WRITING TO THE OFFICE MANAGER OR PHYSICIAN.

PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT PRINTED NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_