QUASAR
HEALTH SOLUTIONS
Revolutionizing Global Healthcare

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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Patients Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Obtain From: Release To: _____

_____ _____

I authorize to ☐ **Release** and/or ☐ **Obtain** information and copies of records pertaining to my medical care and treatment.

☐ I authorize the following health care information (check all that apply):

☐ All my health information

☐ My health information related to the following treatment/condition: _____ _____

☐ My health information for the date(s): _____ _____

☐ Other: _____

Purpose of Request: ☐ Transfer of Care ☐ Personal ☐ Insurance ☐ Attorney ☐ Other: _____

Preferred Delivery Method: ☐ Fax ☐ Mail ☐ Hard Copy ☐ Disc

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES TWELVE MONTHS AFTER IT IS SIGNED OR ON: _____

When my information is used or disclosed pursuant to the on this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA PRIVACY RULE. I have the right to revoke this authorization in writing to the extent that Quasar Health Solutions has acted in reliance upon it. My written revocation must be submitted to Quasar Health Solutions, Attention: Privacy Officer at 3282 Charles Blvd, Greenville, NC 27858.