

### AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I request and authorize:

Peter B. van Dyck, MD & Associates, PA  
4601 Lake Boone Trail, Suite 1B  
Raleigh, NC 27607-7503  
Tel: (919) 781-1800 Fax: (919) 781-1899

To **release & receive** specified Protected Health Information in my patient/client record **to & from**:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

This Authorization includes:

- Medical/Psychiatric Evaluations     EEG/X-ray/Imaging Reports     Telephone Conversations
- Psychological Evaluations     Progress Notes     \_\_\_\_\_
- Laboratory Reports     Treatment/Discharge Summaries     \_\_\_\_\_

Purpose of record release: \_\_\_\_\_ Coordination of care; \_\_\_\_\_ Other: \_\_\_\_\_

Dates of records covered by Authorization: \_\_\_\_\_

Expiration date of Authorization is 2 years from date signed unless otherwise specified: \_\_\_\_\_

I understand that this information is protected under the terms of HIPAA privacy regulations and that storage and release of this information is protected by HIPAA regulations.

I understand that I can withdraw this authorization at any time by notifying Peter B. van Dyck, MD & Associates, PA in writing.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.]

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Relationship or Authority to Sign

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witnessed By