LAKE BOONE TRAIL, SUITE 1B • RALEIGH, N.C. 27607-7503 TEL (919)781-1800 • FAX (919)781-1899

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I request and authorize:

Name: _____

Address: _____

Telephone: _____ Fax: _____

To release specified Protected Health Information in my patient/client record to:

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

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 released 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