RELEASE OF MEDICAL RECORD INFORMATION

4064 Barrett Dr. Unit 9A | Raleigh, NC 27609
Phone: (919) 803-4188 Fax: (919) 803-4117

Release to Live Well Primary Care
This authorization expires ninety (90) days from date of signature

PATIENT NAME_____ DOB_____

Reason for Request: _____ Medical (continuing care) _____Personal _____

Medical (transferring care) _____ Other _____

I hereby authorize the following clinician/facility and staff to disclose my protected health information to Live Well Primary Care:

1. The following person, or facility may release my protected health information.
   Name _____
   Address_____
   Phone (_____)_____ Fax (_____) _____

2. Complete Record _____ Partial Record_____ through_____

ATTENTION: UNLESS YOU SIGN HERE, NO INFORMATION MAY BE RELEASED REGARDING ALCOHOL OR SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH. YES, DISCLOSE THIS INFORMATION _____.

SIGNATURE _____NO. DO NOT DISCLOSE THIS INFORMATION.

3. I understand that my protected health information may be re-disclosed by the person/facility receiving it, and would at that time no longer be protected by federal privacy regulations.
4. This authorization expires ninety (90) days from date of signature or sooner, (1) if at any time I should revoke it, or (2) upon the occurrence of the following expiration event for which this disclosure was authorized.
5. Please FAX all records **to LIVE Well Primary Care** at (919)803-4117.

_____ Date_____
Signature of Patient/Guardian or Representative

Description of representative's authority to act for patient_____

Authorization Form

I authorize LIVE Well Primary Care, PLLC to use and disclose a copy of the specific health and medical information described below.

Name of Patient: _____
DOB/SSN: _____

Description of information on above named patient to be used disclosed:

_____
_____
_____

Name of Recipient: _____
Purpose of Disclosure: _____
_____
_____

If LIVE Well Primary Care requests this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this authorization, and
4. We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed o complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law.

By: _____ Date: _____

(Patient) Or

By: _____ Date: _____

(Patient's Representative)

Description of Representative's Authority _____
_____
_____

Patient Representative Authorization/Proxy Form

This form allows you to choose a patient representative (a designated person authorized by you) that allows LIVE Well Primary Care to disclose/share your medical Information. (Example: Spouse, Parent, Family member, or any person of your choice) You may place limitations on the type of information that is to be disclosed, or choose not to select a representative.

PATIENT NAME: _____

PATIENT DOB: _____ Please

check one:

_____ I DO NOT wish to select a patient representative at this time.

_____ I DO wish to select a patient representative at this time.

I _____ designate _____ (State

relationship to patient) _____ as my representative.

My signature below acknowledges that I give my authorization for LIVE Well Primary Care, PLLC to disclose any and all medical information pertaining to my care to the above named representative. *Please indicate any restrictions/limitations of medical information to be shared with your representative:

_____
_____
_____
_____
_____ My designated representative can be reached:

Phone (Home) _____ Work _____ __

I have reviewed and I understand this form.

__ I understand that I can withdraw my consent in writing at any time.

Patient Signature: _____ Date: _____

Adolescent Care Agreement

(Please read and sign if applicable)

We all realize that this is a special time in your life that involves a lot of physical and emotional changes. Your doctors want to be available to talk about questions you have, and want you to know that any information you share with your doctor will be kept private. Your parents and your doctors know that this may include talking about sex, drugs or alcohol abuse, and may also include advice about prescribing birth control methods. We all agree that is best to talk openly with your parents, but we understand that you may have special needs during your teenage years that require privacy, and we respect that.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

LWPC has permission to provide care to my adolescent child without the presence of a parent or guardian. ◯ Yes ◯ No

Parent /Guardian Signature_____Date_____