**Patient Full Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:**\_\_\_\_\_\_\_\_\_\_\_\_

| **This will authorize:** | **To release medical records to:** |
| --- | --- |
| **Durham Health and Wellness, PLLC**5015 Southpark Dr Ste 110Durham, NC 27713984-219-1562 (p) 984-219-2366 (f)Please check at least one box below* Colleen Prince, RD, PA-C
 | **Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**GENERAL INFORMATION REQUESTED**

| **Medical Information Requested:*** Complete Records
* Lab Reports
* X-Ray Reports
* X-Ray Films
* Immunization
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | **Reason for Release:*** Coordination of Care
* To update my regular provider
* I have been referred to another doctor
* I want/need a second opinion
* I am changing providers
* My insurance changed
* My provider has moved to another practice and requires my records for continuity of care
* I am moving and below is my new address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| --- | --- |

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

I specifically authorize the release of data and information relating to (you must circle yes or no):

Yes No Substance Abuse (alcohol/drug abuse)

Yes No Mental Health/Depression (includes psychological testing)

Yes No HIV-Related Information (includes testing)

This consent may be revoked at any time by notifying the above names provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

*RESTRICTIONS*: This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.