10 Page Drive, Pinehurst NC 28374
Phone: (910) 295-6868 / Fax: (910) 295-8780

Authorization to Discuss Medical Information

Patient Name: _____ Patient Date of Birth: _____

Representative authorized to discuss/review information:
Name: _____
Address: _____
Phone: _____
Relationship to Patient: _____

Extent of Authorization (choose ONE):
A: ☐ Complete medical record including, but not limited to: appointments, medications, lab results, imaging study results, test results, plan of care. Includes records relating to: mental health, HIV/AIDS, alcohol/drug abuse).

B: ☐ Complete medical record with the exception of: mental health records, communicable disease information (HIV/AIDS), alcohol/drug abuse treatment, other: _____

Effective Period:
This Authorization will remain in effect until:
A: ☐ No Expiration Date
B: ☐ Expires _____ (specify expiration date or event)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Print or Type Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)