414 Dabney Drive
Henderson, NC 27536

Henderson Wellness Center, PA

Phone: (252)430-8000
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REQUEST AND AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

From:
Provider/Facility Name _____ Phone Number _____ Fax Number _____

To:
Provider/Facility Name _____ Phone Number _____ Fax Number _____

Patient Name _____ Date of Birth _____ Social Security _____

Patient Address _____ City, State _____ Patient's Phone Number _____

INFORMATION REQUESTED:

O Entire Medical Records O Laboratory Test Results O X-ray, CT, MRI, US and Reports
O Other/Specific Information Only: Please Specify _____

PURPOSE OF RELEASE: (Optional) TRANSFER OF CARE

O Convenience O Dissatisfied with Practitioner O Dissatisfied with Staff
O Moved Out of Service Area O Change of Insurance

COORDINATION OF CARE

O Referral/Consultation O Personal Use O Legal O Other _____

If you DO NOT consent to release of the following records, corresponding boxes must be INITIALED:

O HIV/AIDS Related Records O Genetic Testing Information
O Mental Health Information O Drug/Alcohol Diagnosis, Treatment or Referral Information

By signing below I agree to release the aforementioned health information and I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I understand that I may revoke this authorization in writing at any time, to the extent that action has been taken in reliance upon this authorization.
If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event)
There may be fees for providing copies.

_____ _____
(Signature of patient or person authorized by law) *(Date)*

O Check here if you are the parent or guardian.