AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION:
MEDICAL RELEASE

Patient Name:_____ Date of Birth:_____

If Minor: Mother Name:_____ Fathers Name:_____

Mailing Address:_____

AT MY REQUEST, I AUTHORIZE MY RECORDS TO BE TRANSFERRED: **TO/FROM**

_____

_____

TO DISCLOSE THE FOLLOWING INFORMATION: Please mark appropriate

- ○ Any and all medical records/ transferring care
- ○ Any and all medical records/ Other purpose state why: _____
- ○ Other (specify)_____
- ○ Specifically authorize the release of information relating to:_____
- ○ Substance abuse
- ○ Mental Health/ Psychiatric Evaluation and Treatment
- ○ HIV related information

TO MAKE THE DISCLOSURE: **TO/FROM**

SURF PEDIATRICS AND MEDICINE
(Mailing Address) 5107 N Croatan Hwy Kitty Hawk, NC 27949
(Fax) 252-565-0534 IF OVER 25 PAGES PLEASE MAIL DO NOT FAX

I understand that any disclosure of health information carries with it's the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules.
I understand that I have the right to revoke this Authorization at any time, except to the extend action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above.
Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature and date below or on the following date, event, or condition.
I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____ _____
Signature of Patient/Guardian Relationship to Patient Date

_____ _____
Witness Signature Date

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