PENSLOW MEDICAL CENTER

Patient Authorization for Release of Protected Health Information

Patient Name:_____DOB_____

Address:_____

Last four of SSN _____

I hereby authorize _____ to release my Protected Health Information (information contained in my medical records) to the following entity.

PENSLOW MEDICAL CENTER
206 N DYSON ST
PO BOX 159
HOLLY RIDGE, NC 28445
PHONE: (910) 329-7591 FAX: (910) 329-1592

Description of information to be disclosed: _____

Purpose of disclosure_____

To be read and signed by patient:

I understand the following:

1. I may revoke this authorization at any time by providing written notice to Penslow Medical Center.
2. I may not be able to revoke this authorization once the practice has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3. Penslow Medical Center will not condition treatment or payment based on my signing this authorization.
4. I understand that if my records contain information relating to HIV, AIDS, alcohol abuse, drug abuse, psychiatric conditions, or other communicable disease this disclosure will include that information.
5. This authorization is valid for 6 months from the date signed.
6. I have reviewed this authorization and understand its purpose and intent.
7. I will be able to obtain a copy of this authorization upon my request.

_____ _____

PATIENT/REPRESENTATIVE SIGNATURE DATE