Hormone Wellness MD
950 Windy Road Suite 206 Apex, NC 27502
P: 919 364 3430 F: 833 631 6938
Please fax medical records to the above fax number

Authorization for Disclosure of Health Information

Patient Name: ____ DOB: _____/______/_______

Patient Address: ____

Information that can be released: If specific dates only, list dates: ____
Information to be disclosed (check all applicable items to be released):

	All My Medical Records		History and Physical		Lab Reports		Documents
	Encounter Notes		Image Reports		Medication Records		

Purpose or Need for the Disclosure Is:

	Continued Medical Care		Legal		Other:
	Insurance		Patient's Own Use		

I hereby authorize _______________________________________ to release my medical information from their records.

Healthcare office name: ____

Phone: ______________________________________ Fax: ____

Address: ____

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic testing, sexually transmitted infection, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV).

This authorization expires on: _____________________ or upon the following event: ______________________________
(Date)

If I fail to specify an expiration date or event or condition, this authorization shall remain in effect for one (1) year from the date I sign it.

____ ______________________________

(Signature of Patient or Personal Representative) *(Date)*

If signed by a personal representative, please check the description of the representative's authority:

	Parent		Legal Guardian		Healthcare Power of Attorney		Beneficiary
	Administrator		Executor of Estate		Next of Kin		Other: