DAYSPRING FAMILY MEDICINE

250 WEST KINGS HWY EDEN, NC 27288

Phone (336) 623-5171 Fax (336) 627-5747

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name _____

Patient or Guardian Signature _____ Date _____

Patient Birth Date _____

Street Address _____

Phone Number _____

I authorize _____ to release the

following health information to _____

Phone # _____ Fax # _____

Dates of Service _____

____ ALL RECORDS	____ OFFICE NOTES	____ PATHOLOGY REPORTS
____ LAB REPORTS	____ IMMUNIZATIONS	____ RADIOLOGY REPORTS
____ OPERATIVE REPORTS	____ ER REPORTS	____ CARDIAC REPORTS

___ I do ___ I do NOT authorize release of information related to AIDS or HIV infection, psychiatric care and or psychological assessment and treatment for alcohol and/or drug abuse. Purpose for disclosure:
___ change of Doctor ___ moved ___ other

Please indicate your acceptance by initialing the following statements:

___ I understand that unless earlier revoked, this authorization will expire on ___/___/___.

___ I understand that I may revoke this authorization at any time by notifying Dayspring Family Medicine Associates in writing, but if I do it won't have any effect on any actions Dayspring Family Medicine Associates took before it received the revocation.

___ I understand that Dayspring Family Medicine cannot make me sign this authorization as a condition to receive treatment from Dayspring Family Medicine Associates except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

___ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug, alcohol abuse, mental illness or communicable disease, including HIV and AIDS.

_____

Signature of Patient or Representative

_____

Printed Name

_____

Relationship of Representative to Patient

_____

Date