AUTHORIZATION TO *RELEASE* HEALTH INFORMATION

New River Family Wellness, PLLC
420 East Second Street, West Jefferson, NC 28694

---

1. _____ _____
Name of Patient **Birth Date**

_____ _____
Street Address **City, State, Zip**

2. **AUTHORIZES:**

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

3. ***TO RELEASE*** **PROTECTED HEALTH INFORMATION To:**

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

4. **INFORMATION TO BE RELEASED:**

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ X-Ray Reports
- ☐ Consultations
- ☐ Physician Progress Notes
- ☐ List of Allergies
- ☐ Physician Orders
- ☐ Entire Record
- ☐ Lab Results
- ☐ Medication Lists
- ☐ Problem List
- ☐ Immunization Records
- ☐ Other: _____

For the following dates: _____

In compliance with Federal and State Mental Health Law:

___ Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug/alcohol abuse may be released to the recipient noted above.

___ Copies of medical records, including information of the diagnosis and/or treatment for AIDS/HIV (including testing) may be released to the recipient as noted above.

5. **PURPOSE FOR NEED OF DISCLOSURE: (Check all that apply)**

- ___ Further Medical Care
- ___ Insurance Eligibility/Benefits
- ___ Legal Investigation or Action
- ___ Personal
- ___ Changing Physicians
- ___ Other: _____

6. **Privacy.** I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information may be redisclosed without obtaining authorization.

7. **Your Rights with Respect to This Authorization:**
   - **Right to Receive Copy of This Authorization-** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
   - **Right to Refuse to Sign This Authorization-** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment, on my decision to sign this authorization.
   - **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Director of Health Information Management. I am aware that the revocation will not apply to information that has already been released in response to this authorization.

8. **Expiration Date:** This authorization is good until the following date(s) _____ or event(s) (specify event) _____.
   If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.

   I have had an opportunity to review and understand the content of this authorization form.
   By signing this authorization, I am confirming that it accurately reflects my wishes.

9. **Signature of Patient:** _____ **Date:** _____

   (If signed by person other than patient, state relationship and authority to do so.)

   Patient is: ___ Minor ___ Incompetent ___ Disabled ___ Deceased

   Legal Authority: ___ Custodial Parent ___Legal Guardian ___ Executor of Estate of Deceased
   ___ Power of Attorney for Healthcare ___ Authorized Legal Representative

   Signature of Witness: _____ **Date:** _____