Impact Primary and Urgent Care

Patient Name________________________

AUTHORIZATION FOR RELEASE OF

Date of Birth_________________________

PROTECTED HEALTH INFORMATION

Requested Action:

- ❑ Provide a copy of my Health Information to:
- ❑ Discuss my Health information with:
- ❑ I request to review my information on site

Impact Primary and Urgent Care
315 Franklin Plaza **Phone 919-496-4976**
Louisburg, NC 27549 **Fax 919-496-4978**

Name:______________________________________Phone:________________Fax:________________

Adress:_________________________________City:__________________State:_______Zip:_________

Purpose:

- ❑ Continuation of Care
- ❑ Insurance
- ❑ Legal
- ❑ Other (specify)____

Treatment Dates:

- ❑ Treatment dates from:
  _____________to _______________or
- ❑ All treatment dates

Information to be Released: (check boxes below)

- ❑ Entire Record
- ❑ Summary Information (Discharge Summary, Operative Notes/Procedure notes, Radiology, Pathology, Laboratory, EKG, ED notes, Clinic Visits, Consults)
- ❑ History and Physical
- ❑ Radiology Reports
- ❑ Laboratory Report
- ❑ Pathology Report
- ❑ Clinic Notes
- ❑ Operative Notes
- ❑ Ed Record
- ❑ Discharge Summary
- ❑ Immunization Record
- ❑ PT/OT Notes
- ❑ Discharge Instructions
- ❑ Clinic Notes
- ❑ Other (please specify)
- ❑ Information contained in the Patients medical record related to psychiatric and /or psychological diagnosis, status, symptoms, prognosis, and treatment to date (May require physician approval.)

❏ Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse.

I Understand that:

- The Information to be released may include a diagnosis or reference to the following conditions: genetic testing, sickle cell anemia, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
- Without my express revocation, this authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
- I may revoke this authorization in writing at any time, expect to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosure prior to the revocation to the extent that this authorization was relied upon for such disclosures made prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to redisclose by the recipient and may no longer be protected by the HIPPA Privacy Rule.

Signature: Signature is required to validate this authorization: This is voluntary, if not signed Impact Primary and Urgent Care will still provide treatment and seek payment for services provided. According to the North Carolina General Statutes, Health Information Management may charge for copies of medical records. This authorization will expire on ________________________________.

____ ____________ _________________________

Signature of Patient/Guardian/Personal Representative Date Relationship (parent, guardian etc.)

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Witness