AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use of disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulation, including HIPPA. I release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

The following individual/organization is authorized to release the requested health information: **Name:** ______________________________

Dates of service being requested: From:________________ To:____________________

The following is a list of specific information being requested:

[x] Admission history and physical	[x] Lab reports	[x] Progress notes
	[x] Medication records	[x] Radiology reports
[x] Anesthesiology records	[x] Nurse's notes	[x] Rehabilitation
[x] Consultation notes	[x] Office visit notes	[x] Surgery records
[x] Discharge summary	[x] Outpatient records	[x] Vital signs
[x] EMS report	[x] Pathology reports	[x] ER notes and records
[x] P.T. and O.T. records	[x] Physicians' orders	[x] Itemized statement for services rendered

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy note requires a separate authorization.

This information may be disclosed to and used by the following individual or organization:

Name: **Moser and Bruner, P.A.** **Telephone:** **(910) 276-2631**

Address: **Post Office Box 1827, Laurinburg, NC 28353** **Fax:** **(910) 276-0326**

Purpose of disclosure: [x] Legal Review [ ] Insurance Review [ ] Other

I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with a right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign the authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

I understand any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. **I understand that any photocopy of this document will be considered as valid as an original.** Unless otherwise revoked, this authorization will expire on the following date, event or condition: upon conclusion of Moser and Bruner, P.A. representation. **If I fail to specify an expiration date, event or condition, this authorization will expire in one year.**

Signature:________________________________ **Witness:**________________

Printed Name:____________________________ **Date:**____________________

(Patient/Authorized Representative)

Address:________________________________ **Date of Birth:**______________

SS#:________________

If Authorized Representative, please indicate relationship to patient: [ ] Spouse [ ] Parent [ ] Other