BRUNSWICK FAMILY MEDICINE

Authorization for Disclosure of Health Information

RELEASE **FROM** BRUNSWICK FAMILY MEDICINE

Patient Name: □Mr. □Mrs. □Miss □Ms. □Dr. _____
First Name Middle Initial Last Name

Home Phone #: _____ **Cell Phone #:** _____ **Date of Birth:** _____

Address: _____
City State Zip Code

I, the above patient, hereby authorize the following facility to disclose information, as I have indicated below, from my health record:

□ **Brunswick Family Medicine**
3960 Executive Park Blvd., Suite 600
Southport, NC 28461
910-454-4343 (phone)
910-457-9209 (fax)

□ **Dr. Slade Suchecki**
5106 Wrightsville Ave.
Wilmington, NC 28603
910-395-6400 (phone)
910-457-9209 (fax)

Information to be disclosed:

□ Complete health record
□ Hospital records
□ Appointment information
□ Laboratory tests
□ Progress notes and/or Consultation reports
□ Other _____
□ Diagnostic reports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

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

Practice Name: _____

Phone Number: _____ **Fax Number:** _____

Address: _____
City State Zip Code

The purpose of disclosure:

□ Transfer of Care □ Moving □ Referral □ Continuation of Care □ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 180 days.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Parent or Guardian: _____ Date:_____

Signature of Witness: _____ Date: _____