

MR# _____
ACCT# _____

Authorization to Disclose Medical Information

_____ **Angel Medical Center**
P.O Box 1209
Franklin, NC 28744

_____ **Angel Urgent Care**
195 Franklin Plaza
Franklin, NC 28734

Patient Name _____ Date of Birth _____
Social Security Number _____ Telephone # _____
Address _____

1. I authorize the above provider to disclose to _____
(recipient of information)
Address/Phone Number _____

2. Information to be disclosed under this authorization: _____
(dates of service)
____ Standard information (includes discharge summary, H&P, op note, consult, ER, lab & x-ray results)
____ Discharge Summary ____ ER Record ____ Lab Report ____ X-ray Report
____ Operative Report ____ Pain Clinic Notes ____ EKG ____ X-ray Film
____ Other (specify) _____

3. I understand that if my medical record contains information relating to substance abuse, psychological or psychiatric conditions, genetic testing, behavioral or mental health services, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or other communicable diseases and conditions this information may be disclosed.

4. This information will be used or disclosed for the following purpose _____

5. I understand I have the right to revoke this authorization at any time by presenting a written revocation to the medical records department. I understand a revocation will not apply to information already disclosed and that a 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 or event: _____.
If an expiration date or event is not specified, this authorization will expire in six (6) months.

6. I acknowledge that the provider noted above may not condition treatment on the completion of this authorization except for those services provided solely for the purpose of creating medical information for disclosure to a third party. The consequences of refusal to sign shall be noted.

7. I hereby authorize the use and/or disclosure of the medical information as described above. I understand this authorization is voluntary. I understand that any disclosure of information may be subject to re-disclosure by the recipient and no longer be protected by federal privacy laws. I understand that I may request a copy of this authorization. A photocopy of this authorization may serve as an original.

By signing below, I acknowledge the statements in this authorization form.

Signature of Patient/Legal Representative*

Date

*If signing as a legal representative of the patient, please describe the authority that permits you to authorize disclosure:

Signature of Witness/Date

ID verified and/or copied: _____(initials)