Graham County Hospital Clinic

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DAVID ATKINS, MD LUKE HANDY, MD GAGE REICHERT, PA KAT DAVIS, PA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
To be completed by the patient to authorize disclosure to self or others.

_____
Patient Full Name Phone Number

_____
Current Address Date of Birth

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure from:
(FROM)

Provider's Name/Office _____ Phone Number _____.

Address _____ Fax Number _____.

3. Type and amount of information to be used or disclosed is as follows: include dates where appropriate)

____ entire record from (date) _____ to (date) _____.
____ laboratory results from (date) _____ to (date) _____.
____ most recent history & physical from (date) _____ to (date) _____.
____ x-ray and imaging reports from (date) _____ to (date) _____.
____ consultation reports from (date) _____ to (date) _____.
____ medication list from (date) _____ to (date) _____.
____ list of allergies from (date) _____ to (date) _____.
____ immunization record from (date) _____ to (date) _____.
____ most recent discharge summary from (date) _____ to (date) _____.
____ other from (date) _____ to (date) _____.

4. This information may be disclosed to and used by the following individual or organization:
(TO)

Provider's Name/Office _____ Phone Number _____.

Address _____ Fax Number _____.

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.

This authorization will expire on the following date or event: _____ .

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____
Personal Representative's Relationship to Patient