UROLOGY ASSOCIATES OF SOUTHEASTERN NORTH CAROLINA, PA
1905 GLEN MEADE ROAD
WILMINGTON, NC 28403
Phone 910-763-6251 Fax 910-763-7408

Patient Name_____ Chart# _____

Date of Birth _____ PHONE _____

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (HIPPA)

Health information records that may be used/disclosed/released (initial all that apply):

_____ All Records

_____ Only Records Dated from _____ to _____

Specify if these records are to be used/disclosed/released:

Mental health _____Substance use disorder treatment of HIV/Aids _____Other _____

Persons that may use/receive information:

_____ _____

_____ _____

Expiration: This authorization is effective for 1 year after the date of signature

RELEASE OF MEDICAL RECORDS

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED:

From: Name of Practice _____

Address: _____

_____

Phone: _____ Fax: _____

To: Name of Practice _____

Address: _____

_____

Phone: _____ Fax: _____

Signature of Patient _____ Date _____

Printed Name _____ Relation to Patient _____

If signed by someone other than patient, please indicate relationship (e.g. parent, POA, etc)