

Authorization for Release of Records

Patient's Name: _____ **Date of Birth:** _____

Address: _____

Phone: _____ **Email:** _____

I hereby authorize:

Provider and/or Facility: _____

Phone: _____ **Fax:** _____

to disclose the following: (check one)

- **ALL Medical Records.** I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

Restrictions - Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

- Be Included.
 - NOT Be Included.

- **Specific Medical Records:** [DESCRIBE MEDICAL RECORDS (IF APPLICABLE)] _____

My medical records shall be disclosed to the following individual or entity:

HighTide Healthcare
5200 North Croatan Hwy Suite 9
Kitty Hawk, NC 27949
Phone: 252-581-8404
Fax: 833-764-5804

Purpose of Release: Establish primary care.

Expiration: Upon fulfillment of request or for one year.

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

A copy of this authorization is as valid as the original.

Patient or Personal Representative Signature

Date

Printed Name