Community Family Practice, PA
Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

At my request the following information may be released:

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ Marketing* ☐ On site record review by the patient
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):

☐ Other as listed

*Financial compensation is received for this communication.

Entity or person who will send the information:

From: _____
Address: _____
_____
City/State/Zip: _____
Phone: _____
Fax: _____

To: **Community Family Practice**
260 Merrimon Avenue
Suite 200
Asheville, NC 28801
(p) 828.254.2444
(f) 828.254.0660

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

_____Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Revised June 2016