



Amy Edwards
& ASSOCIATES, PLLC
ATTORNEYS AT LAW

Phone 252.758.3430

www.NCLawyersForYou.com

Fax 252.752.0844

Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying the providing doctor, treatment provider, office or facility in writing.

Patient name: _____

Social security number: _____-_____-_____

Date of birth: _____

Current Phone Number: _____

Doctors/Medical Offices or Facilities who will provide the information:

Firm receiving the information:

Amy A. Edwards & Associates, PLLC
313 West Second Street
Greenville, NC 27834
www.NCLawyersForYou.com
(252) 758-3430

Page 2 of Authorization for Release of Information

I authorize my entire medical file to be provided, including but not limited to the following:

- Name(s) of my treating physician or practitioner.
- Records of recommended treatment, including advice to seek counseling.
- Listing of all my prescriptions.
- Any substance abuse assessment or records related to substance abuse.
- The right to discuss these issues with this facility and treating physician or practitioner.

I authorize the release of this information for three (3) years after the date I sign this Release *unless* I specify time periods here:

From _____ to _____.

Signed this _____ day of _____, 20____.

Write Full Name Here

Sign Here