HIPAA 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 Edwards Family Law
313 West Second Street Greenville, NC 27834
www.AmyEdwardsFamilyLaw.com
(252) 758-3430

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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____.

Written Name: _____

Signature: _____