AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth _____
Client Medical Record # _____ Client SS # _____

All Medical Information including physician notes/summaries and diagnostic results for the periods from _____ to _____.

I, _____ hereby authorize _____ to
(Client's Name) (Recipient Name)
disclose specific health information from the records of the above named client to:

H. Edward Knox
Knox, Brotherton, Knox & Godrey
817 East Trade Street
Post Office Box 30848
Charlotte, North Carolina 28230-0848
(704) 372-1360 (704) 372-7402 fax

for specific purpose(s): REVIEW BY PATIENT AND HIS AUTHORIZED AGENTS OF ALL RECORDS CONCERNING, RELATING TO, AND MADE OR REVIEWED IN CONNECTION WITH THE PATIENT FOR LEGAL PURPOSES.

ALL HEATH CARE RECORDS, INCLUDING BUT NOT LIMITED TO, ANY ADMISSION RECORDS, EMERGENCY DEPARTMENT RECORDS, HISTORY AND PHYSICAL, CONSULTATION REPORTS, LABORATORY REPORTS, X-RAYS, EKG'S, MRI, CT AND ANY OTHER IMAGING STUDIES OR REPORTS, OPERATIVE/PROCEDURE REPORTS, DISCHARGE SUMMARY, PROGRESS NOTES, NURSING NOTES, MEDICATION CHARTS, AND ANY AND ALL OTHER RECORDS, NOTES, OR THE LIKE, AND ANY AND ALL OF THE TREATMENT, EXAMINATION OR PROVISIONS OF ANY AND ALL HEATH CARE SERVICES, INCLUDING ANY REPORTS OF COMMUNICABLE DISEASES (INCLUDING BUT NOT LIMITED TO HIV) OR TESTS FOR INFECTION, AS WELL AS ANY AND ALL BILLING AND FINANCIAL INFORMATION AND INVOICES, THAT CONCERN OR RELATE TO THE NAMED PATIENT.

I understand that this authorization will expire on the following date, event or condition: One (1) year from the date set forth below.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one (1) year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

THIS AUTHORIZATION HEREBY REVOKES ANY AND ALL PRIOR HEALTH AUTHORIZATIONS.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____
(Signature of Client) (Date) (Witness)

Note: This authorization was revoked on: _____ _____
(Date) (Signature of Staff)