Center for Integrated Health Care, PC (CIHC)

4000 Shipyard Blvd, Suite 100 Wilmington, NC 28403

(910) 796-9969 Fax (910) 796-0270
Russell H. Gerry, MD ~ Internal Medicine

AUTHORIZATION TO RELEASE RECORDS

When completed and signed by you, this form authorizes CIHC to release protected information from your medical and/or clinical record to the person you designate.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of my / my child's medical records from / to:

Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And to furnish them from / to:
Center for Integrated Health Care, PC
4000 Shipyard Blvd., Suite 100, Wilmington, NC 28403

\_\_ Medical Records for period beginning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This authorization shall remain in effect until the information is either received or disclosed or I revoke said authorization.

I have the right to revoke this authorization in writing at any time by sending such written notification to CIHC offices. However, my revocation will not be effective to the extent that CIHC has acted in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my medical doctor generally may not condition medical services upon my signing this authorization unless the medical services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and is no longer protected by the HIPAA Privacy Rule (45 C F R parts 160 and 164).

I have carefully read and understand the above statements, and I do herein expressly and voluntarily consent to disclosure of the above information.

Signature: Date: