MID CHARLOTTE DERMATOLOGY AND RESEARCH
SOUTHEAST VULVAR CLINIC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT IF THE ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION IS NOT AN INSURANCE COMPANY OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL REGULATIONS.

REGARDING PATIENT: **MEDICAL RECORD NUMBER:**

LAST NAME **FIRST NAME** **MI**

STREET ADDRESS

CITY **STATE** **ZIP CODE**

DATE OF BIRTH **SOCIAL SECURITY NUMBER**

INFORMATION RELEASED FROM: **INFORMATION RELEASED TO:**

NAME(HEALTH CARE PROVIDER) **NAME(HOSPITAL, MD, AGENT, ETC)**

STREET ADDRESS **STREET ADDRESS**

CITY **STATE** **ZIP CODE** **CITY** **STATE** **ZIP CODE**

PHONE # **FAX #** **PHONE #** **FAX #**

PURPOSE FOR RELEASE OF RECORDS:

[ ] CONTINUING TREATMENT
[ ] LEGAL INVESITGATION
[ ] WORKERS COMPENSATION
[ ] PERSONAL
[ ] CHANGE IN INSURANCE
[ ] MOVING
[ ] STAFF/PHYSICIAN ISSUES
[ ] DISABILITY DETERMINATION
[ ] OTHER _____

I HEREBY RELEASE YOU FROM ALL LEGAL RESPONSIBILITY OR LIABILTY THAT MAY ARISE FROM THIS AUTHORIZATION.

SIGNED _____ **WITNESS** _____
DATE _____