Compassionate Care

Leslie A. Smith, M.D.
400 Shadowline Drive
Suite 201B
Boone, NC 28607
Phone: 828-832-8300 Fax: 828-832-8303

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

Full Name of Patient: ____
Maiden Name/Alias: ____
Patient's DOB: ____________________________ Patient's Phone Number: ________________

Information Requested (X) ( ) Medical Record ( ) Psychiatric Records
******If only a portion of the Medical record or Psychiatric record is required please specify******

( ) Office Notes
( ) Discharge Summary ( ) History & Physical
( ) HIV Test/Status
( ) Emergency Room ( ) X-Ray Report
( ) Laboratory Records ( ) Progress Notes
( ) Radiology Film/Imaging/CD-ROM ( ) Other (Please Specify) __________

Date of service or date ranges requested including month and year: _____________________

The above record is to be released/mailed to the following individual:

( ) Compassionate Care of NC, P.A. (address above)

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON:
( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes ( ) Personal Interest
This authorization must be signed and dated and may be revoked be notifying our office in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner by my choice.

I understand that the medical record released pursuant to this authorization could obtain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protexted by these regulations. I hereby affirm that I have read and fully understood the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature ____ **Date** ___________________

Patient, Parent or Legally authorized Representative