GREENVILLE HEALTH CARE

Authorization to Release Health Information

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

_____ **may release the following information:**
(Name/Address) (Institution to release information)

- o Entire record
- o Office Visit Notes/Labs
- o Psychotherapy Notes
- o Other: _____

Records will be received by:
Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Send the information via mail/fax/Email: _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Representative: _____
Date:_____

*Description of Patient Representative's Authority (attach necessary documentation)

- o Revoked by patient or personal representative (date) _____.

How revoked: _____ orally (in person or via phone) _____ in writing (place copy in patient's file)