RANDOLPH
Specialty Group Practice

☐	☐	☐	☐
Randolph Ortho	**Randolph ENT**	**Randolph Urology**	**Asheboro Gastro**
503 N. Fayetteville Street	124 N. Park St.	132-C W. Miller St.	700 Sunset Ave.
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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, **[name of patient]** _____, **[date of birth]** _____

authorize **[name of facility/provider]** _____

to disclose my health information to **[name and address of recipient]** _____

_____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ Please send the entire medical record (all information) to the above named recipient.

_____ Records from last _____ year(s), including progress notes, lab and x-rays.

_____ Laboratory reports date(s) _____to _____

_____ Diagnostic imaging reports date(s) _____to_____

_____ Progress notes date(s) _____to_____

_____ Other _____

For the following purpose:

Legal _____
Insurance _____
Patient Request _____
Other _____

* The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV/AIDS related health information and/or records

_____ *Mental health information and/or records

_____ *Genetic testing information and/or records

_____ *Drug/alcohol diagnosis, treatment, and/or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed.)

_____

_____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **the medical records department**. Unless revoked earlier, this authorization will **expire 180 days from the date of signing** or upon **[insert applicable date or event of expiration]** _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this 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 be protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative — Date

_____ _____
Print Name of Legal Representative (if applicable) — Relationship of Legal Representative to Individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)