Unifour Medical Commons
240 18th Street Circle S.E.
Hickory, NC 28602
828-322-2550

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Authorization for Disclosure of Health Information

I hereby authorize the disclosure of the following information from the health records of:

Patient's Name: ____ Date of Birth: ____________________

Address: ____ Phone: ________________________

____

This information will be disclosed To:

CATAWBA PEDIATRIC ASSOCIATES, PA
Name of Office/Guardian

240 18th Street Circle SE
Address

Hickory NC 28602
City State Zip

828-322-2550 / 828-322-7748
Phone # Fax #

From:

____
Name of Office

____
Address

____
City State Zip

____________________ / ____________________
Phone # Fax #

For the purpose of____

Information to be disclosed:

☐ **Complete Health Records (including any information relating to AIDS, HIV, Substance abuse, and/or mental health records).**

☐ **Other (please specify)**____________________
____
____

Covering the period(s) of health care from : ______________________ **to** ________________________

Right to terminate or revoke authorization: This authorization shall expire 1 year from date signed. You may revoke or terminate this authorization by submitting a written revocation to our practice.

Potential for re-disclosure: I understand that once the authorized organization or person receives this information, then this information may be subject to re-disclosure. It may not be possible to ensure your right to protection of the privacy of this information once our practice discloses it to another party.

Effect of refusing authorization: If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Rights of the individual: You have the right to contact and request that your information be protected from anyone that you release your health information to.

____ ______________________________
Parent / Guardian Name Relationship to the Patient

____ __________________
Signature of Patient or Patient's Legal Representative Date