CHARLOTTE COMMUNITY HEALTH CLINIC

8401 Medical Plaza Drive, Suite 300, Charlotte NC 28262
⌘ PHONE: (704) 316 6561 ⌘ FAX: (704) 384-1974

Medical Record # _____

Place patient label here

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Autorizacion Para Obtener Informacion De Salud

PATIENT INFORMATION: (*Información del paciente***)**

Date of Birth: *(Fecha de Nacimiento)* _____

Last Name (*Apellido*)	First Name (*Nombre*)	Middle Initial (*Inicial*)
Street Address (*Calle* y *Numero*)		Apt # (*Apartamento #*)
City (*Ciudad*)	State (*Estado*)	Zip Code(*Codigo Postal*)

INFORMATION RELEASE FROM: *(Informacion Viene De)*

Health Care Provider *(Proveedor de Servicios Medico)*

Street Address *(Calle Y Numero)*

City *(Ciudad)* State *(Estado)* Zip Code *Codigo Postal*

INFORMATION RELEASED TO: *(Informacion publicada A)*

CHARLOTTE COMMUNITY HEALTH CLINIC
Health Care Provider *(Proveedor de Servicios Medico)*

8401 Medical Plaza Drive, Suite 300
Street Address

Charlotte NC 28262
City *(Ciudad)* State *(Estado)* Zip Code *(Codigo Postal)*

THIS INFORMATION SHALL INCLUDE THE FOLLOWING: Date(s) of Service of Release _____

- ☐ *Discharge Summary*
- ☐ *History & Physical*
- ☐ *Progress/Office Notes*
- ☐ *Consultation*
- ☐ *Other (Specify)* _____
- ☐ *Operative Report*
- ☐ *Pathology Report*
- ☐ *Laboratory Report*
- ☐ *ECG/EEG Cardiac Cath*
- ☐ *Radiology Report*
- ☐ *Emergency Report*
- ☐ *Progress Notes*
- ☐ *Entire Record*

NOTICE: *This authorization is for DISCLOSURE OF ALL RECORDS, including clinical findings, diagnosis, treatment, assessment, recommendation, for further care, names of health care personnel, dates of hospitalization and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions and/or sexually transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude listed below.*

EXCLUSIONS: _____

PURPOSE FOR DISCLOSURE:

☐ Continuing Treatment ☐ Legal Investigation ☐ Disability Determination ☐ Personal

☐ Other (please specify): _____

RESTRICTIONS:

I understand that the recipient of this information may not use or disclose the information unless authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification but that it will not have any effect on information release prior to notification of cancellation.

SIGNATURE OF PATIENT/LEGAL AUTHORITY

(*FIRMA DEL PACIENTE/AUTORIDAD LEGAL*): _____ **Date (Fecha) :** _____

LEGAL AUTHORITY IS:

☐ *Guardian* ☐ *Attorney-In-Fact* ☐ *Guardian Next of Kin* ☐ *Other: Specify :* _____