PHOENIX HEALTHCARE OF ASHEVILLE, PLLC
E-mail: DH@phoenixhealthcarenow.com

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Name:_____
DOB_____/_____/_____SSN_____/_____/_____
ADDRESS_____CITY_____STATE_____ ZIP CODE_____
PHONE (H) _____(C) _____

I_____ am requesting Phoenix HealthCare of Asheville, PLLC to **DISCLOSE** information of my protected health care to the following person (s)

( ) Spouse_____
( ) Dr.'s phone no. _____
( ) Other: _____
Valid through (dates) _____ or indefinite. □

RELEASE RECORDS information of my protected health care to the following person (s)

RECORDS TO:
I, _____authorize Phoenix HealthCare of Asheville to RELEASE the RECORD information to, in accordance with the laws of the North Carolina and Phoenix HealthCare of Asheville policies:

NAME, ORGANIZATION_____
ADDRESS_____CITY_____
STATE_____ZIP
CODE_____PHONE_____
FAX_____

OR

TO **OBTAIN RECORDS** FROM:
( ) Authorize Phoenix HealthCare of Asheville to OBTAIN medical information from:
NAME.ORGANIZATION_____
ADDRESS_____CITY_____
STATE_____ZIPCODE_____PHONE_____
FAX_____

**Please send to: Phoenix HealthCare of Asheville, PLLC
2149 Riceville Rd., Asheville, NC, 28805**

INFORMATION TO BE RELEASED OR OBTAINED:

Physician notes__ Radiology reports__ Hospital records__ Lab reports__ Emergency room reports__ History and physical__ HIV records __Consultation__ Drug and alcohol __Psychiatric notes__ Complete chart __ Other_____
Dates of Service _____to_____

The purpose for this disclosure of the above information is: __Continuing Care__ Personal Use_____ Other_____

NC law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter and $1.00 per page. I hereby authorize, allow and cause the release the information indicated above. No threat of utter coercive measures have induced me to sign this form and I do release Phoenix HealthCare of Asheville from and covenant not to sue Phoenix HealthCare of Asheville for any claim I have or may in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the 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 protected by those regulations. I further understand that I may revoke this consent to release information at ay time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire in 6 months after the date specified below, or on the date.

Signature: _____Date:_____