Authorization to Release Health Information to
Alzheimer's Memory Center

Patient Information:

Name of Patient:_____ Date of Birth:_____

Address:_____

City, State, Zip:_____ Phone:_____

I do hereby authorize _____
(List applicable facilities/ doctors)

located at: _____ _____
(Address, City, State, Zip) (Phone, Fax)

to release protected health information to:

Alzheimer's Memory Center

7809 Sardis Rd. Charlotte, NC 28270

(P)704-364-4000, (F)704-364-4005

Information to be released (check all that apply):
Dates of treatment to be released: from: _____ to: _____

□ Office visit notes □ Radiology results □ Laboratory results (B12, TSH, Folic Acid, RPR) □ Diagnostic testing, please specify: _____	□ Immunization record □ Neuropsychological evaluation (only psychotherapy notes can be released) □ Financial records □ Entire record

Purpose of release (check reason):
□ Request of individual/personal □ Continued patient care
□ Insurance □ Legal purpose including discussions and proceedings
□ Other_____

Send information via:
□ Fax □ Mail □ E-mail*: _____
□ Other_____
*For email communication I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur. _____
(Initial)

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 understand that:

- I have the right to revoke this authorization at any time. Any revocation, will only apply to records not yet released.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and my treatment will not be conditioned on signing.
- I understand released information may include information about my behavioral/ mental health, drug and alcohol use, sexually transmitted diseases, and communicable diseases such as HIV.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

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City, State, Zip:_____ Phone:_____

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(List applicable facilities/ doctors)

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