Authorization to Release Health Information <u>from</u> Alzheimer's Memory Center

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

I do hereby authorize: **Alzheimer's Memory Center** located at **10801 Monroe Rd, Suite 100 Matthews, NC 28105 (P) 704-364-4000, (F) 704-364-4005**
to release protected health information to:

_____
(List applicable facilities/doctors)

_____
(Address, City, State, Zip)

_____ _____
(Phone) (Fax)

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
- ☐ Insurance
- ☐ Other: _____
- ☐ Continued patient care
- ☐ Legal purpose including discussions and proceedings

Send information via:

☐ Fax ☐ Mail ☐ Email*: _____

*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)

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
10801 Monroe Rd, Suite 100
Matthews, NC 28105
(P) 704-364-4000, (F) 704-364-4005

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