LAKE BOONE TRAIL, SUITE 1B • P.O. BOX 19410 • RALEIGH, N.C. 27619-9410 TEL (919)781-1800 • FAX (919)781-1899

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ______________________

I request and authorize:

Name: ____

Address: ____

Telephone: ________________________ Fax: ____________________________

To release specified Protected Health Information in my patient/client record to:

Name: ____

Address: ____

Telephone: ________________________ Fax: ____________________________

This Authorization includes:

- ❑ Medical/Psychiatric Evaluations
- ❑ EEG/X-ray/Imaging Reports
- ❑ Telephone Conversations
- ❑ Psychological Evaluations
- ❑ Progress Notes
- ❑ ______________________
- ❑ Laboratory Reports
- ❑ Treatment/Discharge Summaries
- ❑ ______________________

Dates of records released by Authorization: ______________________________________

Expiration date of Authorization is 2 years from date signed unless otherwise specified: ________________

I understand that I can withdraw this authorization at any time by notifying Peter B. van Dyck, MD & Associates, PA in writing.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.]

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

______________________________ ______________________________

Signature of Patient or Legally Responsible Person Relationship or Authority to Sign

______________________________ ______________________________

Date Signed Witnessed By