LeBauer Medical Center, PLLC

Authorization Of Use and Disclosure Of Protected Health Information

Patient Name (Printed)_____ Date of Birth _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. This includes information pertinent to mental health, drug/alcohol abuse and HIV/AIDS diagnosis. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations. I understand that there may be information in these records that I would not want released.

I authorize <u>LeBauer Medical Center, PLLC:</u> 3201 Brassfield Rd. #400, Greensboro, NC 27410
2280 South Church St. #202, Burlington, NC 27215

TO RELEASE INFORMATION TO:
Name:
_____
Address:
_____
_____
Phone # Fax #

TO OBTAIN INFORMATION FROM:
Name:
_____
Address:
_____
_____
Phone# Fax#

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):

_____

I authorize the release of medical records covering the period: From:_____ To:_____

I authorize the following information to be sent to the address above: (check as many as apply)

☐ All of the following ☐ Office Visit Notes ☐ Allergy Testing Results ☐ Radiology Reports
☐ Laboratory Test Results ☐ Spirometry Test Results ☐ Other_____

Please read and initial the following statements:

_____a. I understand that unless revoked earlier, this authorization will expire **<u>1 year from date signed below</u>** or date otherwise specified_____.

_____b. I understand that I may revoke this authorization at any time by notifying LeBauer Medical Center in writing, but if I do, it won't have any effect on any actions LeBauer Medical Center took before it received the revocation.

_____c. I understand LeBauer Medical Center cannot make me sign this authorization as a condition to receive treatment

I understand that LeBauer Medical Center assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release LeBauer Medical Center from all legal liability that may arise from this authorization.

Patient or Authorized Representative Signature_____

Date _____

If other than patient, my relationship to the patient is: _____

Brassfield Office Park
3201 Brassfield Road, Suite 400 * Greensboro, NC 27410 * (336) 282-2300 * Fax: (336) 282-0034

Burlington
2280 South Church Street, Suite 202 * Burlington, NC 27215 * (336) 227-1901 * Fax: (336) 227-6616

www.lebauerallergy.com