REACH
Reproductive Endocrinology
Associates of Charlotte

Release of REACH Medical Records

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____
First **Middle/Maiden** **Last**

Address: _____
Street **City** **State** **Zip**

Social Security#: _____ Date of Birth: _____

Information to be released **FROM**:

REACH
1524 East Morehead Street
Charlotte, NC 28207
Phone: 704-343-3400
Fax: 704-370-0427

Information to be released **TO**:

Name: _____

Address _____

_____

Phone _____

Fax _____

Dates of services being requested: From_____ To_____

Check the specific information to be released (used or disclosed):

_____ Office Notes
_____ Radiology Reports/Imaging X-rays
_____ Laboratory/Pathology Reports
_____ Pap & Breast Exam
_____ Other
(specify)_____

Purpose of Disclosure:

_____ Medical Review
_____ Legal Review
_____ Insurance
_____ Personal Use
_____ Other

The named entity is authorized to (select both if applicable):

_____ Use protected health information for treatment, payment and operations
_____ Disclose protected health information to entity named

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when disclosure of the private health information is voluntary. I can refuse to sign this authorization. I understand that I May inspect or obtain a copy of the information to be used or disclosed.

Printed Name: _____

Signature: _____ Date: _____