Authorization for Release of Medical Information
To: **Wintergreen Medical Center**

Patient Name_____ DOB_____

Address_____

Phone _____SSN_____

I hereby authorize _____to release medical information as indicated below to:

Wintergreen Medical Center
324-A Beacon Drive
Winterville, NC 28590
Phone 252-551-5595 Fax 252-321-7762

Information to be released:

	Dates		Dates
☐ All Medical Records	_____	☐ Progress Notes	_____
☐ Lab Reports	_____	☐ Operative Reports	_____
☐ Radiology Reports	_____	☐ _____	_____

Purpose of Disclosure:

- ☐ Changing Physician
- ☐ Consultation/Second Opinion
- ☐ Other _____
- ☐ Insurance
- ☐ Legal
- ☐ School

I specifically authorize the Release of Medical Information relating to:

- ☐ Substance Abuse (incl. alcohol and legal or illegal drugs)
- ☐ Mental Health records (incl. psychotherapy notes)
- ☐ HIV related information (incl. testing and treatment)

X_____ _____
Signature of Patient (or legal guardian) Date

1. I understand that this authorization will expire one year from the date I have signed this form, unless otherwise specified here. _____.
2. I understand that I may revoke this authorization at any time by notifying the providing organization, in writing, and it will be effective on the date notified except to the extent action has already been taken upon it.
3. I understand the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Federal Privacy regulations.
4. I understand that my health care will be provided and payment for my health care will not be affected if I do not sign this form.

X_____ _____
Signature of Patient (or legal guardian/agent) Date

_____ _____
Witness Date

_____
Relationship of Authorized Agent to Patient (if applicable)