CAROLINA WOMEN'S PHYSICIANS, P.A.
2414 Emerald Place
Greenville, NC 27834
Phone: (252) 355-7805
Fax: (252) 758-2970

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize (Name of Facility, Address, Phone, and Fax Number of Facility *Requesting Records From*)

_____

_____

_____

To disclose a copy of health information to (Name of Facility/Person, Address, Phone, and Fax Number)

Carolina Women's Physicians, P.A.
2414 Emerald Place
Greenville, NC 27834

On the following patient:

_____

(Name) (Date of Birth) (Social Security Number)

The information to be disclosed shall be: (Please check)

- □ All records
- □ Labs
- □ Mammogram
- □ Pap Smear
- □ Pathology
- □ Physical Exams/Office Visits
- □ Prenatal
- □ Surgery
- □ Other (Specify) _____

I understand this information will include records relating to:
Alcohol and/or Drug Dependency
HIV Antibody Test and Diagnosis/Treatment
Mental Health Treatment

This Disclosure is being made for the following purpose: (Please check)

- □ Continuing Care
- □ Insurance
- □ Moving
- □ Transfer Care

I understand that the information released cannot be re disclosed. I also understand that the facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signature of Patient/Guardian/Legal Representative Date

_____

Witness Date

For Office Use Only