Hickory Plastic & Reconstructive Surgery Center
Authorization for Release of Health Information

Please note: If any section is incomplete, this form becomes invalid.

Patient:	Name		
	Address		
	City	State	Zip
	Date of Birth	SSN	Phone
I authorize the following facility/provider to release my health information upon this request:			
Health Information	Name		
Released From:	Address	Phone/Fax	
	City	State	Zip
I authorize my health information to be disclosed to:			
Health Information	Name		
Disclosed To:	Address	Phone/Fax	
	City	State	Zip
Please note: If dates are not provided, only the last visit will be disclosed.			

Health Information to be Disclosed:	Copies of clinic notes from	(date) __________ to (date) __________
	Copies of hospital records from (	date) ___________ to (date) __________
	Psychology/Psychiatry records from	(date) __________to (date)__________
	Laboratory reports from	(date) __________ to (date) __________
	Radiology Reports from	(date)__________ to (date) __________
	X-ray films from	(date) ___________to (date)__________
	HIV/AIDS Testing/Treatment from	(date) ___________to (date)__________
	Alcohol/Drug Evaluation/Treatment from	(date) ___________to (date)__________
	Other (Please specify) ____	

Reason for Disclosure:	_____ Personal	_____Disability	_____ Out of town move
	_____ Consult/Second Opinion	_____Treatment	_____ Insurance Application
	_____ Insurance change	_____ Legal	_____ Other

Revocation: I understand that I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, that I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that this authorization will be in effect for 12 months from the date signed unless revoked by me in writing and is only valid for the information specified above. If additional information is requested, a new authorization will be required. Hickory Plastic & Reconstructive Surgery Center will only release information that is dated up to the date signed.

Authorization: I understand that authorizing the release of this information is voluntary. I understand that I may inspect or be provided a copy of the information to be used or disclosed, as provided in CRF 164.524. I understand that any release of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I may contact Hickory Plastic & Reconstructive Surgery Center's Privacy Officer. I understand that Hickory Plastic & Reconstructive Surgery Center will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.
Please allow up to 30 days to process this release.

____ ________________________

Patient/Parent/Guardian Signature (ages 18 and older must sign) **Date**

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Relationship to Patient