**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

**Patient Name: ___________________________________**
**Date of Birth: ___________________________________**
**Last 4 SSN: ___________________________________________**

1. **Authorization**

You may use or disclose the following protected health information:

___ All health care information in my medical records.
___ Other _________________________________
_________________________________

You may use or disclose protected health information regarding testing, diagnosis, and treatment for:
__ HIV/AIDS and other sexually transmitted diseases
__ Psychiatric disorders
__ Drug and alcohol use
__ Genetic disorders

I request and authorize the release of protected health information

TO:

Name_______________________________________
Address_____________________________________
_____________________________________
Phone: _______________ Fax:_______________

FROM :

Authentic Health
15 Yorkshire Street, Suite 201
Asheville, NC 28803
Phone : 828-274-1600 Fax: 828-274-1603

Reason for this authorization:
__ at my request
__ Transfer of Care
__Other

This authorization has no expiration unless I express otherwise in writing.

2. **My Rights**

I understand that I do not have to sign this authorization form in order to receive health care treatment. I may revoke this authorization by writing a letter to Vickery Family Medicine, PLLC. I realize that revocation will not affect any actions already taken based upon this authorization and that revocation may not be possible if the purpose of authorization was to obtain insurance. Once protected health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand that I may contact Vickery Family Medicine at 828-274-1600 if I have questions or any information that needs to be added to this request.

_____________________________________________ ___________
Patient or legally authorized individual signature Date

_____________________________________________

Printed name and relationship if signed on behalf of the patient