Richard D Adelman, MD
7320 Six Forks Rd., Ste 260
Raleigh, NC 27615
Phone – 919-846-9292
Fax – 919-848-3638

Authorization for Use or Disclosure Of Protected Health Information

I hereby authorize the practice of _____
at _____
to convey to **Richard D Adelman, MD** any and all information that he/she possesses relative to my medical records. This is to include all office notes, labs and test results.

_____ Information contained in the patient's medical record MAY relate to
initial psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date.

_____ Information contained in the patient's medical record MAY relate to AIDS
initial or HIV infection, treatment for alcohol and/or drug abuse, and or genetic testing

Please release only the following information for specific dates to the above practice
_____
_____
_____

I direct and hereby authorize the practice of Richard D Adelman, MD to deliver the Protected Health Information specified in this authorization to the party or parties specified in the following format, if available:

___ Hardcopy, (paper) ___ E-mail (not recommended)
___ CD-ROM or Flash Drive ___ No format preference

I give permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire after **90** days after the date signed. The requestor should not re-disclose my medical records to another party without further written consent.

Patient Name: _____

Signature: _____
(patient /guardian)

Date of Birth: _____ SS# _____

Date: _____

Date records sent: _____ by: ___hardcopy ___flash drive ___CD-ROM
Sent by: _____