

Authorization for Use or Disclosure of Protected Health Information

I. _____
hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by:
Richard D. Adelman, MD
7320 Six Forks Road, Suite 260
Raleigh, NC 27615

III. The information is to be provided to:

IV. The purpose or need for this disclosure is: *(please mark the appropriate response)*

- Further medical care
- Personal use
- Attorney
- Insurance
- School
- Disability
- Other *(Please specify)*: _____

V. The information to be disclosed from my health record: *(please mark the appropriate response)*

- Only information related to *(specify)* _____
- Only the time period from _____ to _____
- Entire record

VI. If you would like any of the following sensitive information disclosed, check the appropriate response:

- Substance Abuse Treatment/Referral
- Sexually Transmitted Diseases
- HIV/AIDs-related Treatment
- Psychotherapy Notes Only
- Mental Health (Other than psychotherapy Notes)

I give permission for the information listed above to be released to the above name requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been take to comply with it. The requestor should not re-disclose my medical records to another party without further written consent.

Patient Name: _____

Signature: _____

Patient Date of Birth: _____ Date: _____