Richard D. Adelman, MD 7320 Six Forks Rd, Ste. 260 Raleigh, NC 27615 (P) 919.846.9292 (F) 919.848.3638

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:

_____

_____

_____

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

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: _____