

# Authorization for Release of Medical Information

To: **Wintergreen Medical Center**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ SSN \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release medical information as indicated below to:

<p style="text-align: center;"><b>Wintergreen Medical Center</b> 324-A Beacon Drive Winterville, NC 28590 Phone 252-551-5595 Fax 252-321-7762</p>
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Information to be released:	Dates		Dates
All Medical Records	_____	Progress Notes	_____
Lab Reports	_____	Operative Reports	_____
Radiology Reports	_____		_____

Purpose of Disclosure:

Changing Physician	Insurance
Consultation/Second Opinion	Legal
Other _____	School

I specifically authorize the Release of Medical Information relating to:  
Substance Abuse (incl. alcohol and legal or illegal drugs)  
Mental Health records (incl. psychotherapy notes)  
HIV related information (incl. testing and treatment)

X \_\_\_\_\_  
Signature of Patient (or legal guardian) Date

1. I understand that this authorization will expire one year from the date I have signed this form, unless otherwise specified here. \_\_\_\_\_.
2. I understand that I may revoke this authorization at any time by notifying the providing organization, in writing, and it will be effective on the date notified except to the extent action has already been taken upon it.
3. I understand the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Federal Privacy regulations.
4. I understand that my health care will be provided and payment for my health care will not be affected if I do not sign this form.

X \_\_\_\_\_  
Signature of Patient (or legal guardian/agent) Date

\_\_\_\_\_  
Witness Date

\_\_\_\_\_  
Relationship of Authorized Agent to Patient (if applicable)