SCOTT LURIE, M.D., P.A.

1808 E 7th St. Charlotte NC 28204

Phone 704-376-6577 Fax 704-335-8941

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

PatientName:_____

Patient Address:_____

Patient Date of Birth: _____SSN:_____

I hereby authorize Scott Lurie M.D., P.A. to release (check one):

_____All Medical Records _____Other_____from my medical records to :
Name of organization or person:_____
Address:_____City_____State_____Zip
Code_____Telephone:_____-
Fax_____

Purpose for Release:_____Coordination of Treatment Other_____

I hereby authorize _____to release the following to Scott Lurie, M.D

_____All Medical Records _____Other_____

Purpose for Release: _____Coordination of Treatment_____Other_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding. I understand that I can revoke this consent at any time, by so informing Scott Lurie, M.D., P.A. in writing. However, my revocation will not be effective to the extent that action has been taken in reliance or the authorization, nor if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to consent a claim.

I understand that contents may be subject to facsimile transmission. I also understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentially Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law I understand that my psychiatrist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information to a third party

I understand that if my records contains information relating to HIV infection, AIDS, or AIDS related conditions, alcohol/drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sigh this authorization and that my refusal to sigh will not affect my ability to obtain treatment, payment for service, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g. insurance company) for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given. If treatment is research related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

Signature of Patient or Guardian Date

_____ _____