



## Authorization for Use and Disclosure of Protected Health Information

Patient's Name: \_\_\_\_\_

Patient's Birth Date: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

Records From: Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, & Zip \_\_\_\_\_

*Please send copies of all requested information as soon as possible to the address listed below:*

Records To: Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, & Zip \_\_\_\_\_

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. I authorize use and/or disclosure of certain protected health information (PHI). I agree that a copy or fax of this release shall be as valid as this original release. 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_ SEND ALL MY RECORDS

\_\_\_ RECORDS FROM (DATE) \_\_\_\_\_ TO (DATE) \_\_\_\_\_

\_\_\_ ONLY RECORDS PERTAINING TO \_\_\_\_\_

*If verbal consent: This form was read to the patient over the phone and patient consented to release records.*

\_\_\_\_\_  
Read By

\_\_\_\_\_  
Witness #1/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness #2/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

This authorization will expire on: \_\_\_\_\_

**Wilmington Health**  
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