

AZALEA COAST PLASTIC SURGERY, P.A.
1604 PHYSICIAN'S DRIVE, SUITE 103
WILMINGTON, N.C. 28401
PHONE NUMBER: (910) 762-1234 FAX: (910) 762-1232

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 : _____