AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Charles Jahrsdorfer, MD

3282 Charles Blvd | Greenville NC 27858 | Phone: (252)756-3713 | Fax: (252)756-5920

Patients Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

Obtain From: ______________________
____
____

Release To: CEFM
3282 Charles Blvd.
Greenville, NC 27858

I authorize Carolina East Family Medicine to ☐ **Release** and/or ☐ **Obtain** information and copies of records pertaining to my medical care and treatment.

☐ I authorize the following health care information (check all that apply):

☐ All my health information

☐ My health information related to the following treatment/condition: ______________________

☐ My health information for the date(s): ______________________

☐ Other: ______________________

Purpose of Request: ☐ Transfer of Care ☐ Personal ☐ Insurance ☐ Attorney ☐ Other: __________

Preferred Delivery Method: ☐ Fax ☐ Mail ☐ Hard Copy ☐ Disc

Patient Signature: ______________________ Date: ____________

Witness Signature: ______________________ Date: ____________

THIS AUTHORIZATION EXPIRES TWELVE MONTHS AFTER IT IS SIGNED OR ON: ______________

When my information is used or disclosed pursuant to the on this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA PRIVACY RULE. I have the right to revoke this authorization in writing to the extent that Carolina East Family Medicine has acted in reliance upon it. My written revocation must be submitted to Carolina East Family Medicine, Attention: Privacy Officer at 3282 Charles Blvd, Greenville, NC 27858.