
James Biddle, MD

# Patient Authorization to Release Medical Records From Asheville Integrative Medicine

Patient Name: _____ DOB: _____

I authorize Asheville Integrative Medicine and/or the doctors listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below. I understand Asheville Integrative Medicine is not authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I further understand that other doctors may charge me for copies of records.

## Description of the information to be disclosed *(check all that apply)*:

[ ] The patient's medical records from the previous 2 year(s).

[ ] Only Specific Medical Data/Information as: (Please Check)
- [ ] Xray Reports(s): _____
- [ ] Lab(s): _____
- [ ] H&P: _____
- [ ] Notes: _____

To_____ _____
(Doctor's Name) (Phone/Fax #)

This authorization **shall/shall not** expire (please circle and/or enter date) _____After this date, if one is entered, Asheville Integrative Medicine can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

The patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization. I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

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