NATALIE A. DOYLE, M. D., P. A.

The Center for Medical Weight Loss
Wilson County Infusion Center

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NATALIE DOYLE, M. D. TRACEY P. SHERROD, ANP-C

BOARD CERTIFIED
INTERNAL MEDICINE

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

_____

(PATIENTS NAME – PLEASE PRINT) **(DATE OF BIRTH)** **(SOCIAL SECURITY #)**

I hereby authorize: **Disclose information to**:

Doctor/Facility: _____ Doctor/Facility: _____

Address: _____ Address: _____

_____ _____

Fax#: _____ FAX# _____

Please release the following medical information on the above referenced patient:

( ) Clinical notes, lab, x-ray reports and immunizations related to the following date of service or condition:
_____
( ) Entire medical record including any immunization records
( ) HIV Results
( ) Any restrictions: (Please list)
_____

This disclosure is being made for the following reason(s):

_____ Transfer of Care _____ Attorney _____Referral _____ Moved out of area

_____ Insurance _____ Workmen's Compensation _____ Personal Use

_____ Other: Please describe: _____

I understand that this authorization is voluntary and I may refuse to sign this authorization.
I understand this authorization is subject to revocation at any time by written notification by me except to the extent that the facility which is to make the disclosure has already acted in reliance on it.
I understand my signature on this form authorizes the release of my personal Health Information to the entity listed until revoked by me in writing or in 1 (one) year.

_____

(DATE) **(Signature of patient / Legal Representative)**

_____

(Witness) **(Relationship of Legal Representative to Patient)**

(INTEROFFICE USE ONLY)
ACCOUNTING OF DISCLOSURE

RECORDS RELEASED:
( ) FAX ( ) MAILED ( ) OTHER

DATE: _____ INITIALS_____

RECORDS RECEIVED:

DATE: _____