Medical Release
Awakenings Infusion Center of North Carolina, PLLC

Medical Records Release Form

1. Authorization
    a. I authorize Dr. ____
    to use and disclose the protected health information described below to Awakenings Infusion Center of North Carolina.

2. Effective Period
    a. This authorization for release of information covers the period of healthcare from:
        i. all past, present, and future periods.

3. Extent of Authorization
    a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person/organization I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

______________________________ ____________________ ____________
Signature of Patient Date Time

____
Printed Name of Patient

CONFIDENTIAL

Medical records may be provided to the patient or faxed to (919) 590-1599.