Awakenings Infusion Center of North Carolina
500 Holly Springs Road, Suite 106
Holly Springs, NC 27540
Phone (919) 285-3222 Fax (919) 590 1599

Medical Records Release

1. Authorization
    a. I authorize ____
       (enter name of clinic or provider)
       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 informationcovers the period of healthcare from:
        i. all past, present, and future periods.

3. Extent of Authorization
    a. General: 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).
    b. Specific: ____

       ____________Last 2 Treatment Records______________________________

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.

8. Please return by fax to (919) 590 1599 Attn: Awakenings Infusion Center.

____ ____________________ ____________
Signature of Patient Date Time

____
Printed Name of Patient