REACH
Reproductive Endocrinology
Associates of Charlotte

Authorization for Use and/or Release of Medical Records

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____
First Middle/Maiden Last

Address: _____
Street City State Zip

Social Security #: _____ Date of Birth: _____

INFORMATION RELEASED **FROM:**

Facility Name:_____

Address: _____

_____

Phone #: _____

INFORMATION TO BE RELEASED **TO:**

REACH
Attention: New Patient Liaison
1524 East Morehead Street
Charlotte, NC 28207
Fax: 704-370-0427

Dates of services being requested: From _____ To: _____

Please send the following information:

- ❏ **Pap Smear (required)**
- ❏ Radiology Reports / Imaging X-rays
- ❏ Laboratory / Pathology Reports
- ❏ **Physical Exam (required)**
- ❏ **Office Notes (required)**

Purpose of Disclosure:

- ❏ Medical Review
- ❏ Legal Review
- ❏ Insurance
- ❏ Personal Use
- ❏ Other _____

The named entity is authorized to (select both if applicable):

- ❏ Use protected health information for treatment, payment and operations
- ❏ Disclose protected health information to entity named.

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), AIDS related complex (ARC) and / or human immunodeficiency virus (HIV).

I understand that I have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when disclosure of the private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of this information to be used to disclosed.

Printed Name: _____

Signature: _____ Date: _____