

Seaside Wellness of Shallotte, USPS: PO BOX 929 Shallotte NC 28459
Fedex, UPS, others: 4748 Main Street Shallotte NC 28470
Phone: 910-754-2273 Fax 910-754-2254
Release of Health Information

This authorization permits Seaside Wellness of Shallotte to use and/or release the patient's health information for the purpose(s) described below.

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

Contact Number: _____

Recipient(s): Seaside Wellness may use and/or release the information checked below to the following person or entity for the purposes listed on this form.

Name: _____

Address: _____

Phone: _____ Fax: _____

Type of Information to be used and/or released:

Entire Record Billing/Insurance Records Office Visit Notes Psychotherapy Notes*

*if for psychotherapy notes, any other records must be requested on a separate form. (No other boxes should be checked)

Records from _____ to _____ or the past _____ year(s)

Lab/X-ray results from dates or related to _____

Other _____

Purpose for the use or release is: Establish Care Continuation of Care Transfer of Care

Do not include: Mental Health Records Communicable Disease (HIV/AIDS) Alcohol/drug abuse treatment

This authorization will expire in 90 days.

Format for Delivery: secure email to amanda.danford@rdmgpa.com; secure fax to 910-754-2254 or USPS to PO BOX 929, Shallotte NC 28459 or Fedex/UPS/third party carrier to 4748 Main Street Shallotte NC 28470

Patient Rights and Signature: You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. The termination will not apply to any releases of information that happen before we receive a written termination from you. The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization. You do not have to sign this authorization to receive treatment from this practice. You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above. All changes or updates to this form must be made in writing and signed by you (the patient) or your personal representative.

Patient or Personal Representative

Date

Personal Representative Authority