AUTHORIZATION TO USE AND OR DISCLOSE PHI

This form is provided to you, the patient, to use as an official document giving us permission to send your health information to another party, or to receive it from another party. If you have any questions about managing how your information is shared, please contact Angie Barker, Office Manager.
angie@zackhallmd.com

I hereby authorize Zack Hall, MD PLLC to receive my personal health information as identified below:

To: Zack Hall MD PLLC
217 Turner Dr STE F
Reidsville, NC 27320
Fax 336.342.6068

From: _____
_____
_____
_____

Please release this information for the following purpose(s): _____
_____

I specifically authorize the use or disclosure of the following health information and records, if such records exist (please check):

___ **All Medical records (Office notes, H&P, Specialist Reports, Imaging and Diagnostic Studies, Laboratory results, Pathology Reports)**
___ **Only the records specified here:**_____

* Please initial the following items if you allow them to be included in the use or disclosure of your health information.

___ HIV/AIDS related health information
___ Mental Health related information
___ Genetic testing information
___ Drug and alcohol diagnosis, treatment, or referral
___ Psychotherapy notes (if this authorization is used for the release of psychotherapy notes, it cannot be combined with other information.

I have read the following statements:

1. I understand that I may revoke this authorization at any time by notifying the practice in writing, but it will not affect actions that took place before I revoked the authorization.
2. I understand that if the entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by those entities, and is no longer protected. Therefore, I release Zack Hall, MD, PLLC, its employees, and my physicians from all liability arising from this disclosure of my health information.
3. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that the authorization will expire in 180 days from the date signed below.
4. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

_____ _____ _____
Patient or Patient Representative's Signature | Patient or Patient Representative's Printed Name | Date of Birth

_____ _____
Address | Date Signed

_____ _____
Witness Signature | Date Signed