

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION: *MEDICAL RECORD RELEASE*

Please fill out the following information about your prior doctor's office

AT MY REQUEST, I AUTHORIZE: _____ (Practice Name)
_____ (Address)
_____ (Phone) _____ (Fax)

TO DISCLOSE THE FOLLOWING INFORMATION: any and all of the medical records pertaining to the treatment of _____ (Patient Name) ____/____/____ (Date of Birth), last seen on _____ 20____ (Date Last Seen)

DISCLOSE TO: M.T.CURRY INC (Michelle T. Curry M.D.)
733 VOLVO PARKWAY, SUITE 200
CHESAPEAKE, VA 23320
PH: 757- 547- 5851
FAX: 888-371-4920

PURPOSE OF DISCLOSURE: At the request of the individual/legal guardian:

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I understand that I have the right to revoke this Authorization at any time, except to the extent action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. *(The written revocation must be legible and include the name and date of birth of the individual, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to receive the information, the signature of the person with legal authority for authorization/revocation, and if not the individual, a description of their legal authority for authorization/revocation, and their phone number.)*

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event or condition:

I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

Signature of Patient/Parent/Legal Guardian

Date