
**Mailing Address:**
**PO BOX 3788**
**Wilmington, NC 28406**

**Location Address:**
**1717 Shipyard Blvd Ste 220**
**Wilmington, NC 28403**

**T: (910) 254-9464 F: (910) 254-3474**
**www.wilmingtonendo.com**

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**I** _____ _____
(Print Full Name) (Date of Birth)

**Hereby authorize the release of my health information**

**From:**

**Name:** _____

**Address:** _____

**Phone & Fax #:** _____

**To:**

**Name:** _____

**Address:** _____

**Phone & Fax #:** _____

**I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.**

**Purpose of disclosure:** _____

**Information requested:** _____

_____

**I give my permission for the information listed above to be released to the above name requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not redisclose my medical records to another party without further written consent.**

**Records requested for personal, legal, or insurance purposes are subject to a minimum $10 fee based on the North Carolina General Statutes 90-411 (Record Copy Fee Code). There is no fee for records requested by other physicians for continued medical care.**

**Date:** _____ **Signature:** _____
(Patient or Legal Representative)

**Witness:** _____