



Mailing Address:
PO BOX 3788
Wilmington, NC 28406

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

Phone: (910) 254-9464 Fax: (910) 254-3474

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

Hereby authorize the release of my health information

From:

Name: _____
Address: _____
City, State, Zip: _____

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.

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

Witness: _____