Claude Luvis MDPA
2682 Court Dr. Suite B.
Gastonia, NC 28054

Tel - (704) 824-0500
Fax - (704) 824-1600

Authorization to Release Health Information

I. *PATIENT INFORMATION*

Patient's Full Name ______________________ Date of Birth __________ Social Security Number __________

Patient's Address ______________________ Patient's Home Phone Number __________

City, State ________ Zip Code ________ Telephone ________ Patient's Work Phone Number __________

II. *HEALTH INFORMATION RELEASE INSTRUCTIONS*

Information to be released FROM:

Practice/Physician's Name ______________________

Address ______________________

City, State ________ Zip Code ________ Telephone ________

Information to be sent TO:

Practice ______________________

Address ______________________

City, State ________ Zip Code ________ Telephone ________

III. *AUTHORIZATION*

I ____________________, do hereby authorize the above named to release my "Health Information", as defined below: (check one)

______ All Medical Records

______ All Medical Records from ______________ (Date) through ______________ (Date)

______ All Medical Records EXCEPT ______________________ (List exceptions)

______ ONLY Medical Records pertaining to ______________________ (List conditions, treatments or type of medical records)

NOTICE: Unless excluded above, this Authorization is for FULL DISCLOSURE of ALL RECORDS.

IV. *PURPOSE OF INFORMATION RELEASE*

- ☐ Transfer of Medical Care
- ☐ Disability Determination
- ☐ Personal Injury
- ☐ Insurance Purpose

V. *HEALTH INFORMATION PROTECTION AND PORTABILITY ACT (HIPAA) DISCLOSURES*

The Recipient of this Health Information may not use or disclose the Health Information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This Authorization may be revoked in writing at anytime, except to the extent that action has been taken in reliance on this Authorization. Unless otherwise revoked, this Authorization will expire ninety (90) days from the date signed below this Authorization is fully understood and is made voluntarily on my party.

SIGNATURE: Patient ______________ DATE ________ WITNESS ______________ DATE ________

Authorization for Release of Information to Family and/or Friends

Name of Patient: ______________________________________ Date of Birth: ____________

At the request of the patient, Claude Luvis, MD, PA is authorized to release protected health information about the above named patient to the entities below.

Entity to receive Information: (Initial each that is subject to this authorization)

_____ Leave information on the voicemail.

_____ Give information to spouse.

_____ I consent to receive phone calls from Claude Luvis MD, PA for my protected healthcare and other services at the numbers I provide, including my wireless number if I choose to provide it. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____ Give information the the following persons: ____

Description of information to be released:

_____ Financial Information

_____ Information results from tests or x-rays

_____ Family Billing Information

_____ Medical Information as follows: ____

_____ Other information as described: ____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Claude Luvis, MD, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

____ ____________________

Signature of Patient or Personal Representative Date

____

Description of Personal Representative's Authority (attach necessary documentation)