Headache Wellness Center

1414 Yanceyville Street Greensboro, NC 27405 * Ph 336-574-8000 * Fax 336-574-8008

AUTHORIZATION TO REQUEST AND RELEASE MEDICAL INFORMATION

Patient's Name: ____ Date of Birth: ___________________________

Current Phone Number: ___________________________________ Chart # _______________

I authorize Headache Wellness Center to:

REQUEST my medical records from:
____
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RELEASE my medical records to:
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Below is a description of the information that may be exchanged for dates _________________ through _____________.

☐ All ☐ Lab results and EKG (last 6 months only) ☐ Office Visit Notes ☐ MRI/MRA/CT scan (reports only)
☐ Billing statements ☐ Other: ____

I understand that information disclosed may include medical information related to alcohol, psychiatric care, psychological assessments, substance abuse, sickle cell anemia, gene-related impairments and/or HIV/AIDS if applicable.

I understand that the exchanged information will be used for continuity of care or _______________________.

I understand that this authorization is voluntary. I understand that I may revoke this authorization in writing at any time, but understand that revocation will not apply to information that has already been released in response to this authorization. I release Headache Wellness Center and any member of their staff from all liability regarding the disclosure of this information.

This authorization will expire on _______________ or one year after the date I have signed it.

____ ___________________________
Signature of Patient or Representative* Date

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* Relationship of Representative