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:

_____
_____
_____

☐ **RELEASE** my medical records to:

_____
_____
_____

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. I further understand that information disclosed may be subject to re-disclosure and would no longer be protected by Federal HIPAA Privacy Law.

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

_____ _____
Signature of Patient or Representative* Date

_____
* Relationship of Representative