

Michael Weizman, MD Meredith Polansky, MD

 Jodi Schwab, MD Andrea L. Preston, MD

***STANDARD AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION***

**REQUESTED INFORMATION TO BE DISCLOSED:**

* Last History & Physical
* Progress Notes from the last year
* Labs, Imaging, and other tests or studies from past five years
* All consultation notes

*FOR THE PURPOSE OF CONTINUITY OF CARE, PERSONAL USE OR OTHER*

**DISCLOSED BY: DISCLOSED TO:**

 Our Family Doctor

 43 Oakland Rd. Asheville, NC 28801

 f# (828) 252-2555 ph# (828) 252-2511

I understand the information being released may include diagnosis of and prognosis about psychiatric and substance abuse disorders, stds, HIV infection and AIDS. My authorization will be valid until I revoke it in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal laws or regulations. A photocopy and/or facsimile of this authorization may be considered as valid as the original.

PRINTED PATIENT NAME DATE OF BIRTH

PATIENT OR GUARDIAN SIGNATURE DATE SIGNED

YOU MAKE REVOKE OR TERMINATE THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A WRITTEN REVOCATION TO OUR PRACTICE MANAGER: KAREN FISHER. THE INFORMATION RELEASED MAY BE DISCLOSED AGAIN BY THE PERSON OR ORGANIZATION TO WHICH IT IS SENT. IT MAY NOT BE POSSIBLE TO ENSURE YOUR RIGHT TO PROTECTION OF THE PRIVACY OF THIS INFORMATION ONCE OUR FAMILY DOCTOR DISCLOSES IT TO ANOTHER PARTY. YOU HAVE THE RIGHT TO INSPECT ALL DOCUMENTS PRIOR TO DISCLOSURE. PLEASE LET US KNOW WHEN SIGNING THIS DOCUMENT IF YOU WISH TO INSPECT YOUR DOCUMENTS AFTER PRINTED AND PRIOR TO DISTRIBUTION.