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1321 North Center Street  
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**Hudson Office**  
286 Pine Mountain Road  
Hudson, NC 28638  
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## AUTHORIZATION OF HEALTH INFORMATION DISCLOSURE

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

FOOTHILLS INTERNAL MEDICINE  
1321 N. CENTER STREET  
HICKORY, NC 28601

FOOTHILLS INTERNAL MEDICINE  
286 PINE MOUNTAIN ROAD  
HUDSON, NC 28638

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

\_\_\_\_\_ Complete health records

\_\_\_\_\_ Lab results/X-ray reports

\_\_\_\_\_ Physical exam

\_\_\_\_\_ Consultation reports

\_\_\_\_\_ Immunization record

\_\_\_\_\_ Other (please specify): \_\_\_\_\_

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and be used by the following individual or organization.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the practice administrator. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Signature of witness

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_