



AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL RECORDS

I hereby request my medical records be sent to:

1321 N. CENTER STREET
HICKORY, NC 28601
OFFICE (828) 322-3898 • FAX (828) 322-5485

Gerri Morrison, FNP-BC

286 PINE MOUNTAIN ROAD
HUDSON, NC 28638
OFFICE (828) 728-1998 • FAX (828) 728-1996

Jennifer Woodstock, PA-C

Persons Authorized to Use or Disclose Information
(where records are coming from)

Persons to Whom Information May Be Disclosed
(where records are going to)

Doctor _____

Doctor _____

Address _____

Address _____

City _____ State _____

City _____ State _____

Information to Be Used or Disclosed

The information covered by this authorization includes: _____

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Foothills Internal Medicine. You should contact Brandi Guarino, HIPPA Compliance Officer to terminate this authorization.

Name of Patient (Print or Type) _____ Date of Birth _____

Signature of Patient _____ Date _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____

Expiration Date of Authorization

This authorization is effective for one year unless revoked or terminated by the patient or the patient's personal representative.