

Pinehurst Radiology
30 Memorial Drive
Pinehurst, NC 28374
Phone: 910-295-4400 Fax: 910-295-2810

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

(Name of the entity)

may release the following information:

____ Mammograms on DICOM CD ____ Reports

____ Other _____

Entity or person who will receive the information:

Pinehurst Radiology
30 Memorial Drive
Pinehurst, NC 28374
Phone: 910-295-4400
Fax: 910-295-2810

Other

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)