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 or through POWERSHARE ____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** ______________________________
____
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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

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Description of Personal Representative's Authority (attach necessary documentation)
Revised Oct 2016