George A. Alsina, MD
Jeffrey S. Beecher, DO
Adam P. Brown, MD
George V. Huffmon, III, MD
Thomas E. Melin, MD
J. Alex Thomas, MD

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Full Name: _____

Address: _____

Date of Birth:_____ Patient SS #:_____ Phone #: _____

I_____ hereby authorize
(Patient or Responsible Party)
_____ to disclose specific health information from the records

of the above-named patient to: **Atlantic Brain and Spine** at **2208 S 17th St, Wilmington, NC 28401** and **2800 Ashton Dr.,Suite 200, Wilmington, NC 28412** for the specific purpose(s): (please check one)

Specialist Consultation_____ Transferring my chart and medical care _____

Specific information to be disclosed (please choose one):

My entire chart, including all medical records, documents, x-rays, scans, etc. _____

Medical record for the period_____ through_____

A specific portion/section of the record as follows:

_____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign a Revocation form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Patient)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Legal Guardian)	*(Date)*	*(Relationship)*

2208 S 17th St
Wilmington, NC 28401
Phone: (910) 763-3333
Fax: (910) 763-3336

2800 Ashton Dr., Suite 200
Wilmington, NC 28412
Phone: (910) 799-2262
Fax: (910) 799-2943