

THOMAS & GODLEY, PLLC

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AUTHORIZATION TO DISCLOSE HEALTH AND/OR FINANCIAL INFORMATION

CLIENT NAME: _____ DOB: _____

Date of Request: _____ Expiration Date: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

1. Provider Name: _____

2. **Information to be sent to:** **Ben S. Thomas [as above]**

3. For the purpose of: _____

4. Description of information to be disclosed (dates included when appropriate):

___ consultation reports of _____

___ entire file

___ office notes/records from _____ to _____

___ allergies list

___ discharge summary

___ history and physical

___ immunization record

___ laboratory results

___ medication list

___ problem list

___ x-ray and imaging reports

___ other: _____

5. 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.

6. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received.

_____ Initial

Signature of Client or Client's Representative

Witness

Printed Name of Client's Representative

Relationship to Client