

# VICKERY FAMILY MEDICINE

## Authorization to Use or Disclose Protected Health Information

Patient Name

Date of Birth

Social Security Number

Reason for this authorization:

At my request

Other

**Authorization:** You may use or disclose the following protected health information:

All health care information in my medical records

Other (Please specify):

You may use or disclose the following protected health information regarding testing, diagnosis, and treatment for:

HIV/AIDS and other STDs

Psychiatric Disorders

Drug and Alcohol use

Genetic disorders

I request and authorize the release of protected health information

**From:** Physician or Practice Name

Address

Phone Number

Fax Number

**To:** Vickery Family Medicine  
15 Yorkshire St, Suite 201  
Asheville, NC 28803

Phone: (828) 274-1600

Fax: (828) 274-1603

This authorization has no expiration unless I express otherwise in writing

**My Rights:** I understand that I do not have to sign this authorization form in order to receive health care treatment. I may revoke this authorization by writing a letter to Vickery Family Medicine, PLLC. I realize that revocation will not affect any actions already taken based upon this authorization and that revocation may not be possible if the purpose of authorization was to obtain insurance. Once protected health information is disclosed the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature

Date

Printed Name and relationship if signed on behalf of the patient