

**Charles J DePaolo, MD, PA 3B McDowell St Asheville NC 28801  
Phone: 828-225-1920 Fax: 828-225-1924**

**Authorization to Receive Health Information**

**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip code

**Name & address of Covered Entity authorized to release information:**

\_\_\_\_\_

\_\_\_\_\_

**Forward information to:**

**Charles J DePaolo, MD, PA  
3B McDowell St Asheville NC 28801  
Telephone: (828)-225-1920 Fax: (828)-225-1924**

**The information below will be used for patient care. Description of the protected health information to be disclosed and need:**

\_\_\_\_\_

\_\_\_\_\_

**This authorization shall be in effect until I revoke it: at which time this authorization to use or disclose this protected health information expires.**

**RIGHTS OF THE PATIENT**

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the practice's Privacy Contact at

**Charles J DePaolo, MD, PA 3B McDowell St Asheville NC 28801.**

\_\_\_\_\_  
Signature of Patient or Personal Representative Date: \_\_\_\_\_

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