

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

Authorization to Send Patient Records or For Patient to View Records

Patient Information:

Name of Patient _____ Date of Birth _____

Name & address of Covered Entity authorized to release information:

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Name & address of person or entity receiving information:

Description of information to be released/reviewed at the request of the patient:

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that 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.

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

Signature of Patient or Personal Representative Date _____

Print or Type Name of Patient or Personal Representative

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