AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION:
MEDICAL RELEASE

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

If Minor: Mother Name: _____ Fathers Name:_____

Mailing Address: _____

AT MY REQUEST, I AUTHORIZE MY RECORDS TO BE TRANSFERRED:

TO: Dr. Phillip Austin @ Dare Direct Care
2522 S. Croatan Hwy St 1B, Nags Head, NC 27959

TO DISCLOSE THE FOLLOWING INFORMATION:

- Any and all medical records/ transferring care
- Specifically authorize the release of information relating to:
  - Substance abuse
  - Mental Health
  - HIV related information

TO MAKE THE DISCLOSURE:

FROM: SURF PEDIATRICS AND MEDICINE
(Mailing Address) 100 EAST DUNE ST NAGS HEAD, NC 27959
(Fax) 252-565-0534

I understand that any disclosure of health information carries with it's the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules.
I understand that I have the right to revoke this Authorization at any time, except to the extend action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above.
Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature and date below or on the following date, event, or condition.
I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____ _____
Signature of Patient/Guardian Relationship to Patient Date

_____ _____
Witness Signature Date

Phillip Austin, MD

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Kill Devil Hills NC 27948
252- 261-1304 Phone
252-565-0534 Fax
• surfpediatrics@yahoo.com • www.surfpediatrics.com