Amy Edwards Family Law
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Authorization for Release of Medical Records/Information

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. I understand that I may revoke this authorization at any time by notifying the providing doctor, treatment provider, office or facility in writing.

Patient name: _____

Social security number: _____– _____– _____

Date of birth:_____

Current phone number:_____

Doctors/medical offices or facilities who will provide the information:

_____

_____

_____

Person receiving the information:

Amy A. Edwards
Attorney at Law
313 West Second Street
Greenville, NC 27834
(252) 758-3430
Amy@AmyEdwardsFamilyLaw.com

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I authorize my entire medical file to be provided, including but not limited to the following:

- Name(s) of my treating physician or practitioner.
- Records of recommended treatment, including advice to seek counseling.
- Listing of all my prescriptions.
- Any substance abuse assessment or records related to substance abuse.
- The right to discuss these issues with this facility and treating physician or practitioner.

I authorize the release of this information for three (3) years after the date I sign this Release *unless* I specify time periods here:

From _____ to _____.

Signed this _____ day of _____, 20___.

_____
Write Full Name Here

_____
Sign Here