Back To Basics
1503 Elm Street, Suite C
Sanford, NC 27330
Phone: (919) 895-6339 Fax: (919) 590-1981

Authorization to Release Protected Health Information

I authorize Back to Basics Medical Practice and/or Robert W. Patterson, M.D., to disclose information to:

Name: _____

Address:_____

Fax #: _____

I authorize the release of the protected health information of :

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State:_____ Zip Code: _____

Telephone: (___)_____

Information to be released (please check specific documents):
_____Office Notes
_____Immunization Records
_____Labs
_____Radiology Reports
_____Pathology Reports
Other (please be specific):_____

Please list specific treatment dates _____

**This release extends to include all records pertaining to psychiatric or mental health notes, chemical dependency, and/or the release of information pertaining to sexually transmitted diseases or related illnesses unless indicated to exclude this information by initialing here. _____

I am requesting that this information be release for the following purpose:
□ Continued Patient Care (Please specify:_____)

□ Legal Purposes □ Personal Use □ Disability □ Insurance

_____ _____ _____
Signature of Patient/Authorized Representative Print Name Date

If Authorized Representative, please indicate authority to sign: parent guardian power of attorney other_____