Biltmore Medical Associates, P.A.

Specialists in Internal Medicine

Lucian C. Rice, M.D.
W. Virgil Thrash, M.D.
James D. Ladd, M.D.
Thomas W. Rennard, M.D.
James K. Andrews, M.D.
Alan L. Morgan, M.D.
Kelly Largent, M.D.
Melissa Ballard, FNP
Pegi Deitz, FNP

147 Asheland Avenue
Asheville, NC 28801
Telephone: 828-258-1188
Fax: 828-251-1801

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH 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.

Patient Name: ____________________________________ Date of Birth ___________________

Address: ____

Telephone: ________________________

I authorize the release of individually identifiable health information from:

Doctor/Clinic Name: ____

Doctor/Clinic Address: ____

____

Release to: Biltmore Medical Associates
147 Asheland Avenue
Asheville, NC 28801
Phone: 828-258-1188 Fax: 828-251-1801

Information to be disclosed:

____ Complete health record (**Last 2 years only**), including all images (x-rays, photographs, etc.)
____ Complete health record (**Last 2 years only**), excluding all images

OR
Select from the following (check as many as apply):

____ Discharge Summary
____ History and Physical Examination
____ Consultation Reports
____ Progress Notes
____ Laboratory Tests
____ X-ray Reports
____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human immunodeficiency Virus) infection.
____ Mental health care or services
____ Psychotherapy Notes
____ Treatment for alcohol and/or drug abuse
____ Photographs, videotapes, digital or other images

_____ Other (please specify) ____

____

This information is being requested for the following purpose:

__________ Transfer of Medical Care

__________ Other

This patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on ____/____/____ or on the happening of ____

Initials: __________

b. I understand that I may revoke this authorization at any time by notifying Biltmore Medical Associates in writing, but if I do it will not have any effect on any actions Biltmore Medical Associates took before it received the revocation.

Initials: __________

c. I understand that Biltmore Medical Associates cannot make me sign this authorization as a condition to receive treatment from Biltmore Medical Associates except:

(i) when Biltmore Medical Associates provides me with research-related treatment; or
(ii) when Biltmore Medical Associates provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Initials: __________

Biltmore Medical Associates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(**Form MUST be completed before signing)**

____
Signature of Patient or Representative

____
Date

____
Print Name

____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

____

____