AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ________________________ Date of Birth: _______________
Phone Number: ________________________ Email Address: _______________

Authorization

I authorize the release and disclosure of my protected health information (PHI) by any healthcare provider, medical practice, hospital, or facility that maintains my medical records to the receiving healthcare provider or practice identified on this form. This authorization is for the purposes of continuity of care, medical evaluation, consultation, and treatment planning.

This authorization allows the receiving provider to request, obtain, review, and retain my complete medical records on my behalf, as permitted by applicable state and federal laws.

Information to Be Released

☑ Complete medical records

Receiving Practice

Signature Hair Restoration
4000 Ossi Ct, Suite 171
High Point, NC 27265
Phone: 336-793-3010
Secure Email: medicalrecords@signaturehairrestoration.com

Expiration of Authorization

This authorization is valid for twelve (12) months from the date of signature unless revoked in writing by the patient.

Patient Rights and Acknowledgment

- I understand that I may revoke this authorization at any time by providing written notice.
- I understand that information disclosed under this authorization may be subject to re-

disclosure and may no longer be protected by HIPAA.
• I understand that signing this authorization is voluntary and that treatment is not conditioned upon signing this form.

Patient Signature: ______________________________ Date: ______________

Representative Name (if applicable): ______________________________

Relationship to Patient: ______________________________

This authorization is intended to comply with HIPAA regulations (45 CFR §164.508).