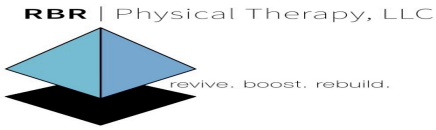

1300 Corporation Parkway, STE B
Raleigh, NC 27610
Phone (919) 917-7729 Fax (919) 400-4178

Authorization to Use and/or Disclose Health Information

Patient Name: _____ SSN: _____

Date of Birth: _____ MR#: _____

1. I authorize the use and disclosure of the above individual's health information as described below:
   a. The following individual or organization is authorized to make the disclosure:

      _____

      _____

      Phone: _____ Fax: _____

2. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

   □ Office visits from (date) _____ to (date) _____
   □ Lab results from (date) _____ to (date) _____
   □ Xray and imaging reports from (date) _____ to (date) _____
   □ Consultation reports from (MD's names) _____
   □ Entire record
   □ Other, please specify: _____

   _____

3. This information may be disclosed to and used by the following individual/organization:

   _____

   _____

   Phone: _____ Fax: _____

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the address above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire on _____.

I understand that I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the FEDERAL PRIVACY RULE.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, Relationship to Patient: _____

_____ _____

Signature of Witness Date