Seaside Wellness of Shallotte,
USPS, Fedex, UPS, others: 4503 Main Street Unit 1 Shallotte NC 28470
Phone: 910-754-2273 Fax 910-754-2254

Release of Health Information

This authorization permits Seaside Wellness of Shallotte to use and/or release the patient's health information for the purpose(s) described below.

Patient Name:_____ Date of Birth: _____

Mailing Address: _____

Contact Number: _____

Request Records From: Seaside Wellness may use and/or release the information checked below to the following person or entity for the purposes listed on this form.

Name: _____

Address: _____

Phone:_____ Fax:_____

Type of Information to be used and/or released:

___ Entire Record __Billing/Insurance Records ___Office Visit Notes ___Psychotherapy Notes*
*if for psychotherapy notes, any other records must be requested on a separate form. (No other boxes should be checked)

____ Records from _____ to _____ or the past _____ year(s)

____ Lab/X-ray results from dates or related to _____

____Other _____

Purpose for the use or release is: ____Establish Care ____Continuation of Care ____Transfer of Care

Do not include: ___Mental Health Records ___Communicable Disease (HIV/AIDS) ___Alcohol/drug abuse treatment

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This authorization will expire in 90 days.
Format for Delivery: secure email to amanda.danford@rdmgpa.com; secure fax to 910-754-2254 or USPS/Fedex/UPS/third party carrier to 4503 Main Street Unit 1, Shallotte NC 28470

Patient Rights and Signature: You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. The termination will not apply to any releases of information that happened before we receive a written termination from you. The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization. You do not have to sign this authorization to receive treatment from this practice. You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above. All changes or updates to this form must be made in writing and signed by you (the patient) or your personal representative.

_____ _____ _____

Patient or Personal Representative | Date | Personal Representative Authority

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