Scott Lurie MD
1808 E. 7th Street
Charlotte NC 28204
Telephone:704-376-6577 Fax: 704-335-8941

Authorization for the Release of Medical Information

I, the undersigned, authorize Scott Lurie M.D.

- ❑To release
- ❑To obtain
- ❑To both release and obtain

medical information or Personal Health Information (PHI) from/to

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I understand that this information is from my medical record and/or medical care as well as the nature of the release of this information and the purpose for its release. I further understand that this may include but is not limited to information regarding drug abuse, alcohol abuse, psychiatric impairments/treatment and AIDS/HIV status, and that this information is protected under the Federal Regulations governing Confidentiality of Alcohol & Drug Patient Records, 42CFR Part 2.

The purpose of this exchange of information is

- ❑Continuity of care
- ❑Coordination of care
- ❑________________________________

I understand that I have the right to request restrictions on uses and disclosures of protected health information, with my provider's agreement. I request the following restrictions:

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This authorization shall remain in force until I revoke it. I understand that I may revoke it at any time via written or verbal notification but that such revocation does not apply to information already released under the conditions of this authorization. The redisclosure of any information exchanged via this authorization is prohibited without further written authorization by the party signing below.

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Patient/Guardian Signature   Date

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Patient's Printed Name   Date of Birth

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Witness Signature