COMMUNITY HEALTH INTERVENTIONS, INC. SPECIALTY CLINIC
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please fill this page out if you would like to release your healthcare information to Community Health Interventions, Inc. Specialty Clinic

Patient Name: _____ Date of Birth:_____/_____/_____

Social Security Number: _____

I request and authorize _____
Health Care Provide Name
to release healthcare information of the patient named above to:

Community Health Interventions, Inc. Specialty Clinic
2409 Murchison Road – Fayetteville, NC 28301
Phone: (910) 488-6118 Fax: (910) 488-6810

This request and authorization applies to:

Healthcare information relating to the following treatment, conditions or dates:
_____

❑All healthcare information relating to the above OR
❑Records only
❑Lab results and X-ray/Radiology Reports
❑Consultant Notes
❑Other:_____

I authorize the release of STD and HIV/AIDS results whether negative or positive. I understand that Community Health Interventions, Inc. Specialty Clinic will be notified that I must give specific written permission before disclosure of these test results to anyone. ❑Yes ❑No ❑ N/A

I authorize the release of any records regarding drug, alcohol, or mental health treatment to Community Health Interventions, Inc. Specialty Clinic. ❑Yes ❑No ❑N/A

I understand that I have the right to withdraw this consent at any time upon written notice to the Community Health Interventions, Inc. Specialty Clinic Director.

_____ _____/_____/_____
Patient Signature **Date**

_____ _____/_____/____
Parent/Guardian Signature **Date**