Slower Medicine, PLLC
Direct Primary Care – it's about TIME

Kenneth Stone, M.D.
Office: 984-999-1010
Fax: 984-202-2400
drstone@slowermedicine.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient for whom authorization is made:

Full Name: _____

Date of Birth: _____

Address:_____

Phone: (_____)_____

Health care provider or health care entity authorized to disclose this information:

Name: _____

Address:_____

Phone: (_____)_____ Fax: (_____)_____

This information is to be received by:

Dr. Kenneth Stone
Slower Medicine, PLLC
6 Consultant Pl. #100B
Durham, NC 27707

Office: 984-999-1010
Fax: 984-202-2400

Specific information to be disclosed:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

☐ Other: _____

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Include: (*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records
(Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information
(Including HIV/AIDS Test Results)

_____ Genetic Information
(Including Genetic Test Results)

Reason for release of information:

(Choose all that Apply)

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other *(Specify)* _____

The individual signing this form agrees and acknowledges as follows:

(i) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(ii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iii) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(iv) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____