

# Slower Medicine, PLLC

Direct Primary Care – it's about TIME

Kenneth Stone, M.D.  
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## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

### Information regarding patient for whom authorization is made:

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

### Health care provider or health care entity authorized to [ disclose / receive ] this information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### This information is to be [ disclosed / received ] by:

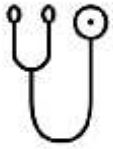
Dr. Kenneth Stone  
Slower Medicine, PLLC                      Office: 984-999-1010  
6 Consultant Pl. #100B                      Fax: 984-202-2400  
Durham, NC 27707

### 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)**

**Reason for release of information:**

\_\_\_\_\_ Drug, Alcohol or Substance Abuse Records

**(Choose all that Apply)**

\_\_\_\_\_ Mental Health Records  
(Except Psychotherapy Notes)

Treatment/Continuing Medical Care

Personal Use

Billing or Claims

\_\_\_\_\_ HIV/AIDS-Related Information  
(Including HIV/AIDS Test Results)

Insurance

Legal Purposes

Disability Determination

\_\_\_\_\_ Genetic Information  
(Including Genetic Test Results)

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: \_\_\_\_\_