AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

blue sky MD™

Patient's Name _____ Date of Birth _____

Which Blue Sky MD office location do you receive care at?

☐ Asheville ☐ Charlotte ☐ Winston-Salem
☐ Hendersonville ☐ Greensboro

I hereby authorize Blue Sky MD and its employees to ☐ release or ☐ obtain (check appropriate box) **information** pertaining to my medical care and treatment, including, but not limited to, mental health records, drug and alcohol abuse records and diagnosis and/or treatment of HIV (Aids Virus).

Release to:

_____
_____
_____
_____

Obtain from:

_____
_____
_____
_____

I understand that I may revoke this consent at any time, and that upon fulfillment of the above stated purpose or lapse of 12 months from the date of signature, whichever comes first, this consent will automatically expire without my express revocation, but that revocation may not be applied retroactively once the information has been released in good faith. I understand Blue Sky MD and its staff cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure and from all legal responsibility or liability that may arise from this authorization.

Signed _____ Date _____

Witness _____ Date _____

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

☐ New patient
☐ Established patient

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