LoginClinics
WHY WALK-IN WHEN YOU CAN LOG-IN?

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize LoginClinics, PLLC to disclose my individually identifiable health information as described below.

- I understand that this authorization is voluntary and I may refuse to sign this authorization.
- I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign.
- I understand that the recipient authorized to receive the information is not a covered entity, e.g., insurance company or non- healthcare provider the released information may no longer be protected by federal and state privacy regulations.
- I understand that this authorization will expire 180 days from the date of signature or at the date or the event specified here: _____(expiration date/event)

I further understand that I may revoke this authorization at any time, by notifying in writing, LoginClinics, PLLC at admin@loginclinics.com or by calling (919)679-1880. I understand that the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

| Patient Name | SSN | DOB | MR # | Account # |
|---|---|---|---|---|
| | | ____.____._____ | | |

| Street Address, City, State, Zip Code | Telephone # |
|---|---|
| | |

Please release this following information for these treatment dates: _____

**The information will be released to:** ❑ Patient/Designee **X** Health Care Entity ❑ Insurance Co ❑ Attorney

| Individual/Organization Name | Telephone # |
|---|---|
| LOGINCLINICS, PLLC | 919-679-1880 |

| Street Address | City, State, Zip Code | Fax # |
|---|---|---|
| 406 US 1 HWY, STE A | YOUNGSVILLE, NC 27596 | 888-315-7712 |

**Purpose of the use and/or disclosure:** **X** Continued Care ❑ Legal Use ❑ Personal Use ❑ Other_____

**Record copy delivery:** ❑ Pick Up ❑ Mail **X** Fax

**Information to be released:** ❑ Labs ❑ Imaging ❑ Progress Notes ❑ Provider Orders ❑ Nursing Notes

I understand that the record might not be complete, and additional documentation could be added after submitting this request.

_____ _____

Signature of Patient or Legal Representation Date

_____ _____

Printed Name of Patient or Legal Representative Relationship to Patient

_____

Representative's Authority to Act for Patient

406 US 1 HWY, STE A
YOUNGSVILLE, NC 27596
Telephone: (919) 679 - 1880
Fax: (888) 315-7712