TELEHEALTH
NURSING & WELLNESS CARE

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize Telehealth Nursing & Wellness Care to disclose my individually identifiable health information, or Protected Health Information (PHI) as described below:

- I understand that this authorization is voluntary, and I may refuse to sign this authorization.
- I further understand that the quality of my healthcare, as well as the coverage of my healthcare will not be affected if I do not sign.
- I understand that the recipient authorized to receive the information is a covered entity, e.g., insurance company or healthcare professional; therefore, the released information is subject to the Privacy Rule and protected by federal and state privacy regulations.
- I understand that this authorization will expire 365 days from the date of signature.

I further understand that I may revoke this authorization at any time by notifying in writing Telehealth Nursing & Wellness Care at info@telehealthnwcare.com. 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 First & Last Name	Last 4 of SSN or DOB	Medical Records #	Account #

Street Address, City, State, Zip Code	Best Telephone #

Most recent treatment dates you have had within the past 1-2 years with your Primary Care Provider or Specialist Provider:

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The information will be released to: ❑ Patient/Designee **X** Healthcare Organization ❑ Insurance Co ❑ Attorney

Individual/Organization Name	Telephone #
Telehealth Nursing & Wellness Care	1-800-609-6170

Mailing Address	City, State, Zip Code	Email
P.O. Box 13746	Durham, NC 27709	info@telehealthnwcare.com

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

Record copy delivery: X Email (info@telehealthnwcare.com) or X Fax (1-800-609-6170)

Information to be released: X Labs X Progress Notes X Provider Orders X Nursing

Notes

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

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Signature of Patient or Legal Representation

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Date

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Printed Name of Patient or Legal Representative Relationship to Patient

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Representative's Authority to Act for Patient