**THRIVE AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**Patient Name:** _____ **Date of Birth:** _____

The above person must indicate when the authorization is to expire:

- ☐ When the information is received
- ☐ In six months
- ☐ In one year
- ☐ In three years **(preferred)**
- ☐ On date _____

**The person named above is or has been a patient of:**
Thrive Personalized Healthcare and Wellness
6401 Morrison Blvd. Suite 2A Charlotte, NC 28211,
Phone: 704-390-7150, Fax: 877-818-9004

Provider's Name (please check):

| | | |
|---|---|---|
| ☐ Dr. Nancy Palermo | ☐ Dr. Amy Fletcher | ☐ Dr. Farangis Goshtasbpour |
| ☐ Dr. Tracy Larson | ☐ Dr. Scott Greenapple | ☐ Dr. Brian Jerby |

**** If you would like us to be able to speak with any other physicians outside of Thrive Center for Personalized Health and Wellness about your medical care, please include their information below:**

**I hereby authorize: _____ to:**
*(Above, please give the name of the person, provider or facility where Thrive Center for Personalized Healthcare and Wellness can obtain your records. Please check all boxes below.)*

- ☐ Request health information from
- ☐ Send health information to
- ☐ Discuss health information with

**I authorize information to be requested or released by representatives of (same as above):**
Name of Physician, Provider or Facility: _____
Address: _____
Fax: _____

**Scope of Information:**

- ☐ (**preferred**) All information regarding assessment, diagnosis and treatment of patient's condition, concern or disease (specify):
  _____
  _____
- ☐ All information regarding care received by patient between the dates of _____ and _____
- ☐ Other information (specify):
  _____
  _____

**Printed Name:** _____ **Date:** _____
**Signature:** _____ **Date:** _____
**Signature of Witness:** _____**Date:** _____

**If not signed by the patient, indicate the relationship of authorizing person to patient:**

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

The above-named person has the following rights:

• The authorization is effective for the above requested and authorized healthcare information only. You may ask for and receive a copy of this authorization form.

• This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that it has been acted upon in good faith while in force.

• You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.

• The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases my not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.

• You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested my assist your healthcare provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries and consultation reports. Records created by and available from other providers, hospitals or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to a copy of your personal health care information free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact a clinic office manager or site administrator for additional information about applicable copying fees.