TEAMWORK HEALTH
BETTER TOGETHER

Authorization for Disclosure of Protective Health Information

I hereby authorize **TEAMWORK HEALTH PLLC** to request and release my medical records to and from all of my healthcare providers for the purpose of coordinating my medical care.

Patient Name _____

DOB _____

- My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.
- I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.
- I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC) and/or human Immunodeficiency virus (HIV).

Signature _____

Date _____

*We encourage those who have questions regarding this policy document to contact us at **919-883-1583.***
*For questions regarding your bill, please e-mail **billing@twhasg.com**.*