

***Village Family Practice of Holly Springs***  
**Authorization to Release Health Information**

Expires upon one time release

**Patient Information**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

**I authorize the practice(s) below to release my health information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please forward/release my health information to: (Fax #: 919-577-2228)**

**Village Family Practice of Holly Springs  
351 West Center Street  
Holly Springs, NC 27540**

The information below is provided at the request of the patient (Describe PHI needed)

\_\_\_\_\_  
\_\_\_\_\_

**This authorization shall be in effect until the information has been forwarded as requested.**

**Patient Information**

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Dr. Gallup at Village Family Practice of Holly springs.

Date \_\_\_\_\_

**Signature of Patient or Personal Representative**

\_\_\_\_\_

**Description of Personal representative's Authority (attach necessary documentation)**