AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to **North Carolina League of Municipalities** upon request in person or by mail to the address specified at the time of the request.

Provider: (name and address)	Patient:
	SS#:
	DOB:
RECORDS AUTHORIZED TO BE RELEASED:	
(Example, specific hospitalization or visit)	
This information will be used for the purpose of:	
☐ Investigating an allegation of abuse ☐ Providing advocacy services ☐ Other activities at the request of the individual	□Verifying my eligibility for services offered by the NC League of Municipalities□Legal representation
authorization at any time by writing to the health ca	te of the signature below. I understand that I can revoke this are provider or to the NC League of Municipalities, but that es made or actions taken before the revocation is received.
I also understand that:	
 I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal. Federal privacy regulations will no longer apply to the information disclosed, and that the NC League of Municipalities may redisclose the information I am entitled to receive a copy of this authorization. A copy of this authorization may be utilized with the same effectiveness as an original. 	Patient or Representative Date
	Name of Representative (print)
	Relationship to Patient