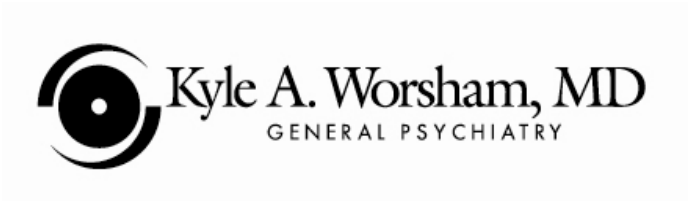

Authorization for the Release of Protected Health Information

1709 Legion Road, Suite 200-B
Chapel Hill, North Carolina 27517

www.kyleworshammd.com
(tel): 919-960-3133(fax): 919-960-3135

Patient Name **Date of Birth**

Parent or Legal Guardian:

This form, when completed and signed by you, authorizes Kyle Worsham, M.D. to release and exchange health information from you or your child's clinical record.

Please list names of provider(s), person(s), agency(s) phone and/or fax number below:

1._____

_____

2._____

_____

3._____

_____

4._____

_____

5. _____

_____

This information will include:

☐ Copies of progress notes
☐ Treatment plan and summary (written and verbal)
☐ All of the Above
☐ Testing/lab results
☐ Other (Specify):

_____

This authorization shall remain in effect for: ☐ 1 year or ☐ until the end of treatment

I understand that I have no obligation to disclose the above information and that I may revoke this consent at any time by notifying this office in writing at the address below. Such revocation will not extend to prior release of information on the basis of this authorization. I further understand that this office has no control over information once it has been released and in consideration of this consent, I release Dr. Kyle A. Worsham from any and all liability arising therefrom.

Signature of Patient / Parent or Legal Guardian Date Witness