Brunswick Sinus

Authorization for Use or Disclose of Health Information

Patient Name: _____ Patient Date of Birth: _____

I hereby authorize _____
(Name of RELEASING facility)

to release the following information to

Dr. Robert Poe
900 N. Howe St.
Southport, NC 28461
P: (910) 457-0734
F: (910) 457-9116

_____
(Description of information to be released)

I understand that I may revoke this authorization at any time by notifying Brunswick Sinus in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Brunswick Sinus prior to receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, or eligibility benefits.

Patient Signature: _____ Date: _____