PAUL A. BUONGIORNO, MD, FAPA

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Re: _____ **Date of Birth:** _____

I hereby authorize:

Name: _____.

Address: _____.

Telephone: _____ **Fax:** _____

To release specified information to:

Name: **PAUL A. BUONGIORNO, M.D.**

Address: **1402 South 17th Street, Wilmington, NC. 28401**

Telephone: **(910)762-8400** **Fax:** **(910)762-9558 *PLEASE FAX**

This data includes:

☐ **Psychological Evaluation** ☐ **Medications**

☐ **Laboratory Reports** ☐

I understand this information will be used for:

☐ **Coordination of Care** ☐ **Treatment Planning**

☐ **Evaluation** ☐

I understand this information will not be further released without my consent.
I understand that there are regulations protecting the confidentiality of authorized information and I hereby acknowledge that this consent is voluntary and valid for 1 year or until this request is fulfilled. I acknowledge that I may revoke this consent at any time by doing so in writing, knowing that action may have already been taken.

_____ _____.

Signature of Patient or Legal Guardian Relationship to Patient

Date: _____.

Thank you!