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John Watts Haresch, MD

**Patient Authorization for Use and Disclosure of Protected Health Information**

**Patient:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I authorize disclosure and use of certain individually identifiable protected health information about me.

**Release from:** \_\_\_\_\_

**Release to:** John Watts Haresch, MD, at the above address

**Information to be released** (specifically describe the information, such as dates of services, type of services, level of detail to be released, origin of information, etc.):

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

The information will be used or disclosed for the following **purpose:** continuity of care or

\_\_\_\_\_

This authorization will expire in 1 year or on: \_\_\_\_\_

I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to: John Watts Haresch, MD, P.O. Box 7277, Kill Devil Hills, NC 27948.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian Date

\_\_\_\_\_  
Print Name of Legal Guardian Relationship to Patient