
**Dr. Keenya Staten, FNP-C**
**Anew Weight Loss Center, PLLC**
**1701 Sunset Ave. Ste 105-C**
**Rocky Mount, NC 27804**
**Phone: 252-969-0432 Fax: 888-977-1275**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize : _____
(your healthcare provider's name or company)

Address: _____
Phone: _____ Fax: _____

to disclose the following information from records of:

Your Legal Name (first, last): _____ Date of Birth: _____

To: Anew Weight Loss Center, PLLC, 1701 Sunset Ave., Ste. 105C. Rocky Mount, NC 27804

Covering the period(s) of healthcare: most recent

From: _____2019_____To:_____2020_____

Purpose of request for medical records: Most recent CBC, CMP, TSH, T4, Hgba1c, and lipid panel

Information to be disclosed:

Office Notes: _____ Lab Reports: __X___ Consultation Reports: _____ Other: _____

Signature: _____ Date: _____
Client/Legal Representative

Witness: _____ Date: _____

**I hereby revoke authorization**.
Signature: _____ Date: _____ Unless otherwise revoked, this authorization will expire 90 days from the date of signature. Treatment and/or payments are not conditioned on signing this authorization. Information used or disclosed pursuant to authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA Privacy Rule 164.508. Anew Weight Loss Center, its employees, officers, and medical practitioners are hereby released from legal responsibility or liability for disclosure of the above information to the extent and authorized herein. I understand this authorization may be revoked, in writing, at any time, except to the extent that action has been taken in reliance on this authorization. Written notice may be given to an administrative staff at Anew Weight Loss Center.