Welcome to North State Medical Center (NSMC)

On behalf of our physicians and staff, we would like to thank you for choosing NSMC as your medical home/Primary Care Practice.

Our practice specializes in providing excellent health care for patients of all ages. We work closely with each patient to provide care for chronic and acute medical conditions while emphasizing preventative health screenings and education. Our practice provides comprehensive health care using advanced medical technology and offers a wide range of convenient on-site services to our patients. In addition, we have access to a wide variety of specialists and diagnostic testing facilities should your care necessitate a referral of any kind.

To help us get to know you and your medical history, please take a moment to fill out the following information. This information will be confidential and will only be reviewed by your physician, physician assistant, or nursing staff.

We have included information about our practice and providers should you wish to schedule an appointment. Please feel free to contact our office at 336-599-9257 with any questions you may have.

We look forward to meeting you soon.

Sincerely,

NSMC Providers & Staff

Meet our Providers

Dr. Patrick Godwin, MD
Internal Medicine and Pediatrics

Dr. Patrick "Rick" Godwin was born in Winston-Salem and grew up in Randolph County. Rick attended Duke University as an undergraduate earning a bachelor's degree of science in Biology. He then did 1 year of research at the Bowman Gray School of Medicine on chemotherapeutic agents before attending the University of North Carolina at Chapel Hill School of Medicine earning a Doctor of Medicine with highest honors and distinction. Rick then did an internship and residency at UNC Chapel Hill in Medicine and Pediatrics. He worked for one year in Durham before coming to Person County to practice medicine.

Dr. Godwin has received numerous awards and filled many leadership roles both academically and within the community. These include:

- Leadership Award (Blue Ribbon Award shown) from the Person County Department of Education
- AOA Honor Society Award
- Resident of the Year at Wake Med
- President of Medical School Student Body at UNC School of Medicine
- Current Chairman of Pharmacy & Therapeutic Committee at Person Memorial Hospital
- Medical Director of the Health Department
- Member of the Board of Nursing at the Nursing School at PCC
- Only Pediatric Doctor who admits patients at Person Memorial Hospital
- Past Chief of Staff at Person Memorial Hospital
- Member of the Board of Person Memorial Hospital
- Rick and his wife Karen have 7 children and enjoy their church and going on mission trips around the world.

Dr. William B. Olds
Family Medicine
Dr. William B. Olds was born and raised in Scotland Neck, Halifax County, North Carolina and was formally educated in and graduated from the Halifax County Public School System. After Receiving a Bachelor of Science Degree in Chemistry, 1968, from A&T State University, Greensboro, North Carolina, he served seven years (1968-1975) as a Captain in the US Air Force, Electronic Systems Officer/Radar Maintenance/Crypto Officer.

Before entering the University of North Carolina School of Medicine, Chapel Hill, NC, (1977-1981) he did advanced studies at UNC while working as a Research Technician, Department of Surgery, NC Memorial Hospital. After receiving his Medical Degree 1981, Dr. Olds completed three years of Family Practice Residency at East Carolina School of Medicine, Greenville, NC (1981-1984).

Roxboro, Person County, NC became home for Dr. Olds, his wife and two young children in the summer of 1984 where he began his Family Practice Medical Career at Person Family Medical Center, 1984-1991. Four of those years he also held the title of the Center's Medical Director. From 1991- May 2019, Dr. Olds continued his Medical Career as a Solo Private Practitioner in Person County. He has been on Staff at Person Memorial Hospital from 1984 until present and served on the Board of Trustees, 1998-2003.

Dr. Olds served as President of Old North State Medical Society 2001-2005, the Nation's second oldest Association of Black Physician, founded in 1887 (served on Board of Directors for several years).

In the 35 years of making Person County home he has remained active in the community: BB&T Community Advisory Board, Piedmont Community College Foundation, Child Protection Team, Home Health and Hospice Advisory Committee, Sertoma Club Charter Member, First Baptist Church.

Tabatha Horner, FNP
Family Nurse Practitioner
Tabatha Horner grew up in Person County and knew one day she wanted to help people in this community. In 2007, she earned her Bachelor Degree of Science in Nursing at Central University in Durham, NC. Knowing she wanted to continue her education, she attended the University of North Carolina at Chapel Hill and graduated in 2011 with a Master of Science in Nursing.

Tabatha started working at North State Medical Center in 2011, as a Board-Certified Family Nurse Practitioner. She enjoys caring for patients of all ages but has a special interest in pediatric patients. She also serves as a clinical preceptor to UNC Nurse Practitioner Program. Tabatha and her husband Brian live in Person County with their 3 beautiful children. Outside of the office, she enjoys being outside with her children, playing golf and camping.

Morgan Orders, PA-C
Physician Assistant
Morgan attended Appalachian State University in Boone, NC where she obtained her bachelor's degree of science in Cell/Molecular Biology with a double minor in Chemistry and Psychology. She then obtained her associate degree in Emergency Medical Science, to which she graduated with high honors. She began her career in healthcare as a Paramedic working for a rural EMS agency in 2019. Knowing she wanted to expand her education further, she attended Gardner-Webb University's Physician Assistant program while continuing to work part-time as a Paramedic.

She graduated in 2023 with a Master of Science in Physician Assistant Studies. Morgan has always had a passion for serving high quality healthcare for all ages to medically underserved and rural communities.
In her free time, she enjoys staying active in her local gym, competing her German Shepherd dog in dock diving competitions, horseback riding with any of her three horses, and reading fiction novels.

Everardo Cuevas-Espinoza, FNP
Family Nurse Practitioner

Everardo Cuevas-Espinoza is a Board-Certified Family Nurse Practitioner. He grew up and went to school in Halifax County where he decided to pursue his interest in nursing. He began his professional career in health care by working as nurse at the local community hospital in South Boston, Virginia in 2004. He attended Old Dominion University where he received a Bachelor of Science Degree in Nursing. While working as a nurse along with a family nurse practitioner, he completed his Master of Science in Nursing and Family Nurse Practitioner program in 2017 at Walden University.

Everardo started working at North State Medical Center in 2019. He is qualified to assess, diagnose and treat a wide array of health care conditions across the entire lifespan. He believes in building relationships with his patients to understand their health care needs and goals better. He also believes that working in collaboration with each client in important to develop a personalized plan to achieve their highest possible state of health. He can speak Spanish and is accepting new patients.

Everardo resides in Virginia. He enjoys reading and staying up to date with the latest information to be able to provide the best possible care. He enjoys attending church, gardening, fishing, listening to music, and traveling.

Patient Centered Medical Home

Our practice functions as a Patient Centered Medical Home. A Patient Centered Medical Home (PCMH) is a team-based approach to health care. The team is made of health care providers, support staff, and most importantly—YOU. As your medical home, we will take care of you when you are sick and when you are well. We will help you set and achieve health-related goals. We will work with you, additional health care providers, and other resources in the community to coordinate your care.

To be an active participant in your care, you should:

- **See your provider at regularly scheduled intervals or as needed.**
- **Maintain and update your medical history with your provider.**
- **Tell your provider about any other health care professionals who care for you.**
- **Remain engaged in your care plan and ask questions about your treatment plans. Give feedback about the care you are receiving.**
- **Feel empowered to take care of your health and collaborate with your provider to make decisions about your treatment.**

Schedule/Cancel an Appointment

Appointments can be scheduled/ cancelled by calling the office at 336-599-9257 and select **option 2**. *Please call the office in advance if there is a change or cancellation, preferably within 24 hours prior to your appointment.*

Clinical Advice

During office hours, contact the office and follow the prompts to speak with the clinical staff. You can also send a message through the Patient Portal for non-urgent clinical advice.

After hours, the on-call provider's contact information is updated daily and can be reached by calling the office and listening to the after-hours message.

Transferring Records

Our practice functions most effectively as a medical home if we have a complete medical history for our patients and information about care obtained outside the practice. To transfer your records to our practice, please fill out the Release of Information (ROI) form (enclosed). Should you need additional forms, feel free to download the form at www.northstatemedicalcenter.com .

For additional assistance, please call the office and follow the prompts for medical records.

Behavioral Health Services

Please speak with your provider for information concerning patient specific Behavioral Health Services.

Referrals

During office hours, you may call the office and select **option 6** on the menu to be directly transferred to the referral coordinator. Listed below are a few of our most common referral centers and a few services they are referred for:

For colonoscopy,

Dr. George
783 Doctor's Court
Roxboro, NC 27573
336-599-2787

GERD, and reflux

Regional GI (Dr. Solik)
2609 N. Duke Street, Suite 503
Durham, NC 27704
919-479-0860

For ultrasound and MRI, Radiology

Durham Diagnostic Imaging
4323 Ben Franklin Boulevard
Durham, NC 27704
919-471-4840

Ear, Nose, and Throat

Duke ENT (Dr. Ryan)
783-C Doctor's Court
Roxboro, NC 27573
336-597-9200

Cardiology

UNC Cardiology
718 Ridge Road
Roxboro, NC 27573
336-599-1077

For headache

Raleigh Neurology
411 Ben Franklin Boulevard
Durham, NC 27704
919-719-8824

Joint, back, and muscle pain, injuries

Emerge Ortho (formerly Triangle Orthopedic)
799 Doctor's Court
Roxboro, NC 27573
336-599-4079

FAQs

To help you get acclimated with our practice we have compiled the answers to some of the most common questions we get from our patients.

What is a Family Physician?

A family physician is a doctor who is devoted to comprehensive health care for people of all ages. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focusing on integrated care.

What ages do you treat?

We treat patients of all ages ranging from newborn to geriatric patients.

What if I need to see the doctor right away?

For life-threatening emergencies, please call 911 or go to the nearest Hospital Emergency Room for treatment.

For other emergent situations, call the office at (336) 599-9257 and we will do our best to address your need.

What is a family nurse practitioner?

A family nurse practitioner is an advanced practice registered nurse that blends clinical expertise in diagnosing and treating health conditions with an added emphasis on disease prevention and health management. Much like a family physician, Family Nurse Practitioners work with patients throughout their lives, diagnosing illness, conducting exams, and prescribing medication.

What information do I need to bring to my appointment?

If you are a new patient, please bring your insurance card, prescription card, driver's license (or other picture ID), a list of your current medications and the completed registration forms found in the form section of our website.

If you are an established patient, please bring your insurance card, prescription card, a list of other health care professionals that you have seen since your last visit, details of any hospitalizations or ER visits, any medications that you are taking (including prescribed, over-the-counter, and herbal remedies), and any questions that you may have.

What if I don't have insurance?

We are committed to serving all patients regardless of financial or insurance status. If necessary, we will work with you to make financial arrangements. However, please be aware that you will be required to pay for your initial office visit upon check-in ($240 fee – not including labs or diagnostic testing).

Our office will provide information on how to obtain coverage if needed. Please contact our office staff if you have any questions.

How do I get a refill for my prescription?

Please contact your pharmacy to request a refill. Your pharmacist will send an electronic request to our office. This not only helps ensure prescription refill accuracy, but it is also the most time efficient for both our staff and most importantly our patients.

609 Professional Drive
Roxboro, NC 27573
Tel: (336) 599-9257 Fax: (336) 599-1593

Patient Information		
Last Name	First Name	Middle Name/Maiden Name
Sex (circle one) Male Female	Date of Birth	Social Security Number
Address	City	State/Zip Code
Home Phone	Cell Phone	Work Phone
Email	Race	Ethnicity (circle one) Hispanic Non-Hispanic
Primary Language	Marital Status	Occupation
Employer	Emergency Contact(s)	Relationship to you
Emergency Contact Phone	Emergency Contact Phone	**Preferred NSMC Provider**
Responsible Party		
Name	SS# of Responsible Party	Birth Date of Responsible Party
Address	City, State, Zip Code	Phone Number(s)
Primary Insurance		
Carrier	Policy Number	Group Number
Policy Holder's Name	Policy Holder's SS#	
Secondary Insurance		
Carrier	Policy Number	Group Number
Policy Holder's Name	Policy Holder's SS#	

Payment Policy

NSMC is committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. *A copy will be provided to you upon request.*

1. **Insurance**. We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare, Medicaid, or other insurers. You are responsible for the balance of the claim.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____	_____
Signature of patient or responsible party	Print Name	Date

609 Professional Drive
Roxboro, NC 27573
Tel: (336) 599-9257 Fax: (336) 599-1593

Patient Name:_____ DOB:_____

Address:_____

PATIENT PRIVACY DIRECTIVES

In our efforts to comply with HIPAA (Health Insurance Portability and Accountability Act), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and coworkers. You must inform us **in writing** of any changes in your directives.

If you would like our office to share medical information with anyone, please list them below.

_____ _____

PARENTS: List all individuals you authorize to bring your children (under 18) in for treatment.

_____ _____

Please provide the name/phone number of people that we may talk with/leave messages with regarding: (Mark "same" if it applies)

Appointments:

_____ _____

Medical Treatments/Test Results:

_____ _____

Billing/Insurance Issues:

_____ _____

Cell number that we may text health information to: _____

Name/Number of Emergency Contact: _____

I acknowledge that I have received a copy of the "Notice Of Privacy Practices" and that everything above is accurate.

_____	_____	_____	_____
Patient/Legal Representative Signature	Printed Name	Date	Staff Signature

PATIENT REGISTRATION FORM: DISCLOSURES AND CONSENTS

Patient Name _____ Date _____

Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to North State Medical Center or the physician/provider individually for services rendered to my dependents or me by the physician/provider or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. **I understand and agree that I will be responsible for any co-pay or balance due that North State Medical Center is unable to collect from my insurance carrier for whatever reason.**

Medicare/Medicaid/Champus Insurance Benefits: I certify that the information given by me in applying for payment under these programs is correct. I hereby direct that payment of my dependent's or my authorized benefits be made directly to North State Medical Center or the physician/provider on my behalf.

Authorization to release non-public personal information: I certify that I have received and read a copy of the North State Medical Center Patient Information Privacy Policy. I hereby authorize North State Medical Center or the physician/provider individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to mail, call, or email: I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a North State Medical Center representative or my physician/provider to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminds, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying North State Medical Center to that effect in writing.

Record Release: I hereby authorize the exchange/release of any information, via paper or electronic review by North State Medical Center with any providers, hospitals, and/or specialist(s) to whom I may receive care from, be referred for care, or to my insurance company to determine benefits and secure payment for services provided. North Carolina law requires us to inform you that your medical records, no matter when created may be released for the purpose of medical or scientific research unless a written objection is received.

Health Data Exchange: I authorize my insurer, health plan, or claims administrator and provider to share with each other my health information for care coordination and quality improvement purposes. This includes sharing my health information from treatment I have received at health care providers not related to North State Medical Center. My insurer, health plan, or claims administrator may also share the above information with a care system or accountable care organization in which North State Medical Center participates. If I do not want my health information shared for these purposes, I may opt out by initialing the statement below.

I do not want my health information shared for the purposes listed under "Health Data Exchange". _____(initials)

Release of Records: I hereby authorize North State Medical Center to disclose specific health information from the records of the patient listed above to the persons listed below. **(Please list those persons who you give consent to be given your health information. Examples include: mother, husband, great aunt, grandfather, etc…)**

Recipient Name	Recipient Name
Address	Address
Phone	Phone
Email	Email

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to submit a written request. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment providers (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), services may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

Authorized Signature:_____ Date: _____

Consent to Treatment: I hereby consent to evaluation, testing, and treatment as directed by my North State Medical Center physician/provider or his/her designee.

_____ _____

Patient Signature (or Guarantor) (Relationship to patient, if applicable) Date

Please print Patient's/Guarantor's name:_____

609 Professional Drive
Roxboro, NC 27573
Tel: (336) 599-9257 Fax: (336) 599-1593

Patient Name: _____ Date of Birth: _____

How did you hear about us? (Circle one)

Newspaper Radio Family/Friend Billboard Other (specify) _____

Name of person who referred you (if any): _____

Allergies: ( ) None

( ) Medication Allergy/Type of Reaction: _____

( ) Food Allergy/Type of Reaction: _____

Current/Chronic Medical Conditions: ( ) None

Past Medical Problems: (Provide Year/Age): ( ) None

Surgeries: (Provide Year/Age): ( ) None

Tobacco Use: ( ) Yes ( ) No

Alcohol Use: ( ) None ( ) Occasionally/Rarely ( ) Weekly ( ) Daily

Illegal/Recreational Drug Use: ( ) Yes ( ) No

Print Name: _____ Date of Birth: _____

Highest Level of Education: _____

Currently Employed? ( ) Yes ( ) No Occupation: _____

Patient Name:_____ Date of Birth:_____ Date: _____

Current Medications: (Please include birth control, herbal medications, vitamins, over-the-counter medications)

Pharmacy Name & Phone Number: _____

Medication	Strength/Dose	How Often Taking

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Patient Name:_____ Date of Birth:_____

Family History: ( ) No knowledge of family history

RELATION	AGE	HEALTH STATUS	DECEASED – Cause, Age at Death
Father			
Mother			
Siblings			
Children			

Please circle any conditions that apply to family members (children, parents, siblings, aunts, uncles, grandparents).

Asthma
Allergies
Arthritis
High Blood Pressure
Diabetes
Heart Disease
Bleeding/Clotting Disorder
Headaches
High Cholesterol
Seizures/Epilepsy
Stroke
Thyroid Disease
Tuberculosis
Chronic Lung Disease
Gallbladder Disease
Cancer
Liver Disease
Kidney Disease
Breast Cancer/Disease
Alcoholism/Substance Abuse
Mental Health Issues

Date of Last Physical: _____ Location: _____

Patient Name:_____ Date of Birth:_____ Date: _____

Review of Symptoms: In the past **TWO WEEKS**, have you experienced:

General	**Yes**	**No**	**Respiratory**	**Yes**	**No**	**Neurological**	**Yes**	**No**
Fever			Cough			Headaches		
Chills			Shortness of Breath			Seizures		
Sweats			Wheezing			Weakness		
Weight Gain			**Gastrointestinal**	**Yes**	**No**	Numbness		
Weight Loss			Nausea			**Psychological**	**Yes**	**No**
Trouble Sleeping			Vomiting			Depression		
Eyes (R, L, Both)	**Yes**	**No**	Constipation			Anxiety		
Vision Change			Abdominal Pain			**Endocrine**	**Yes**	**No**
Eye Irritation			Bloody Stool			Cold Intolerance		
Ears (R, L, Both)	**Yes**	**No**	Constipation			Heat Intolerance		
Hearing Loss			**Genitourinary**	**Yes**	**No**	Excessive Thirst		
Earache			Pain with Urination			Excessive Urination		
Ringing			Frequent Urination			**Hematological**	**Yes**	**No**
Nose	**Yes**	**No**	Difficulty Starting or Maintaining Urination			Abnormal Bruising		
Nasal Congestion			Sexual Difficulties			Abnormal Bleeding		
Sinus Problems			Incontinence			**Skin**	**Yes**	**No**
Seasonal Allergies			Nighttime Urination			Rash		
Mouth/Throat	**Yes**	**No**	**Musculoskeletal**	**Yes**	**No**	Itching		
Trouble Swallowing			Muscle Cramps/Aches			Suspicious Lesions		
Hoarseness			Joint Pain/Swelling					
Sore Throat			Back Pain					
Cardiovascular	**Yes**	**No**	**Breasts**	**Yes**	**No**			
Chest Pain			Lumps or Masses					
Racing/Skipping Heartbeat			Nipple Discharge					
Swelling of Hands/Feet			Tenderness					

Other Symptoms:_____

_____

_____

_____

_____

609 Professional Drive
Roxboro, NC 27573
Tel: (336) 599-9257 Fax: (336) 599-1593

Authorization for the Release of Information

I authorize

(Provider/Practice)_____

(Address) _____

Phone: _____ Fax: _____

To use or disclose information to:

Name: **North State Medical Center**
Address: **609 Professional Drive**
City: **Roxboro** State: **North Carolina** Zip: **27573**
Phone: **336-599-9257** Fax: **336-599-1593**

The protected health information of:

Patient's Name:_____

Date of Birth:_____SS#:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Treatment Dates/Type of Service: _____

Information to be Disclosed (please check information requested):

( ) Entire medical record (if checked, everything except Psychotherapy will be included)

( ) Face sheet	( ) Consultations	( ) Medication/graphic sheets
( ) Pathology report	( ) X-ray reports/films	( ) Discharge summaries
( ) Physician orders	( ) Progress notes	( ) History and physical
( ) Emergency Dept. notes	( ) Operative/procedure notes	( ) Lab reports
( ) Nursing notes	( ) Other	

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials on the lines below authorize the release (if applicable) of information pertaining to:

_____ Mental health _____ Drug/alcohol use/testing _____Genetic testing _____ HIV/AIDS and other communicable diseases

The purpose of the use or disclosure is:

_____ Attorney/legal _____ Continued patient care _____ Social services/disability

_____ Personal use _____ Insurance _____ Other:_____

I understand that:

- I may revoke this authorization at any time.
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.
- If I revoke this authorization, I must do so in writing.
- The procedure for revoking this authorization is to present my written revocation to the health information management department.
- I may refuse to sign this authorization.
- North State Medical Center will not condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this authorization.

I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under Federal medical privacy law. I understand that a fee may be charged for copying the protected health information. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____.

If I fail to specify an expiration date/event/condition, this authorization will expire automatically in ninety (90) days from the date of signature.

Patient Signature (or authorized representative)_____Date_____

Witness Signature:_____ Date_____

Explain the representative's authority to act on behalf of the patient:_____

Date completed:_____**By:**_____ **Total pages:**_____

Sent via: □Mail □Courier □Certified Mail □Faxed to #:_____ **□Pick up □ID checked**