Authorization for Release/Request of Health Information

Patient Name:

____

Date of Birth: _____/_____/_____ SS#: ________-________-_________

Patient Mailing Address:

____

____

This section is to request your medical records FROM YOUR PREVIOUS PHYSICIAN.

Request Records

I hereby request medical records information from: (previous physician)

Name: ______________________________ Address: ____________________

City: ______________________________ State: ________ Zip: _____________

Phone: ________________________ Fax: ________________________

Please send records to: North Carolina Internal Medicine, PC
251 Keisler Drive, Suite 300
Cary, NC 27518
Telephone: (919) 851-1600 Fax: (919) 851-1666

Records to be released:	**Dates:**	
[ ] All Records	From:____________	To:____________
[ ] H & P	From:____________	To:____________
[ ] Progress Notes	From:____________	To:____________
[ ] Lab Reports	From:____________	To:____________
[ ] Radiology Reports	From:____________	To:____________

[ ] Other: ____

This section is to request your medical records FROM US. If you are a new patient this section does not apply to you at this time.

Purpose for disclosure: **[ ] Changing Physicians [ ] Consultation/second opinion [ ] Continuing care**

[ ] Legal [ ] Insurance [ ] Workers Compensation [ ] other: ____________________________

Release Records

I hereby authorize North Carolina Internal Medicine, PC to release my medical information as indicated below to:

Name: ______________________________ Address: ____________________

City: ______________ State: ______ Zip: ________ Phone: ____________ Fax: ____________

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the originator of subject material.

____ ____________________

Signature of Patient / Legal Guardian/ Authorized person Relationship to patient

____ ____________________

Witness Date