AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(Please complete all sections of this form to avoid processing delays.)

Patient's Full Name _____ Date of Birth _____

Street Address _____ (_____) Telephone _____

City, State, Zip Code _____

I consent and authorize (name of facility) _____ to release information from my medical record (protected health information), including current and previous medical records from other practices and practitioners, hospitals and/or clinics. **PLEASE NOTE**: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results.

I agree that a copy of this release or a fax of this release shall be valid as this original release.

INFORMATION TO BE RELEASED:
[ ] Send Entire Record
[ ] Send specific service from (date) _____ to (date) _____

RELEASE INFORMATION TO:
Name _____
Address _____
City _____ State _____ Zip _____

(_____)_____ Telephone (required)
(_____)_____ Fax

PURPOSE: _____ Share with Primary Care _____ Consultation/Referral _____Insurance _____ Legal
_____ Other (specify) _____

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by providing written notification. However, if I choose to do so, I understand that my revocation will not affect any actions taken before receiving my revocation.

This authorization expires sixty days from the date of signature unless otherwise specified: _____

X _____ _____
Signature of Patient (required) **Date**

X _____ _____
Signature of Parent/Legal Guardian/Authorized Person (specify relationship to patient) **Date**

North Carolina General Statutes §90-411 *A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying and mailing records to the Patient or the Patient's designated representative. The maximum fees are: $0.75 per Page for up to 25 Pages, $0.50 per Page for Pages 26 –100, $0.25 per Page for Pages over 100, Minimum fee of $10.00 permitted*