



Authorization to Release Medical Information

For Office Usage:

On this day, _____ (date), we, at Family Centered Healthcare, do hereby, request the release of medical information for patient, _____ (patient's name).

INFORMATION TO BE RELEASED: (Mark all applicable)

- All Information
- All Progress Notes
- Lab Reports
- X-Ray Reports
- Electrocardiogram (EKG)
- Allergy Records
- Immunization Records
- Other: Problem list, Medication list, Past and Family History, Last 2 sets of bloodwork, and progress notes from the past 3 years

RECORDS FROM THE PERIOD: ____/____/____ to ____/____/____ are requested.

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

- Continued Medical Care
- Payment of Insurance Claim
- Legal
- Personal
- Workers' Compensation Claim
- Other: _____

Patient Section:

I AUTHORIZE:

TO RELEASE TO:

Name of sending person/organization

Street Address

City State Zip Code

Family Centered Healthcare, P.A.
1814 Becketts Ridge Drive
PO Box 1119
Hillsborough, NC 27278
Phone: 919.245.3247; Fax: 919.732.3864

as per the aforementioned request.

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By signing below, you are authorizing the office to release any and all information regarding:

Alcohol Drugs Mental Health Sexually Transmitted Diseases HIV AIDS

Signature: _____

If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

X Signature: _____