The Family Doctor

1728 Fordham Blvd, 151 Rams Plaza
Chapel Hill, NC 27514
Ph: (919) 968-1985 Fax: (919) 942-0038

Authorization for Release of Information

Patient Name: ______________________ Birth Date: _____________ Chart #:_____________

I authorize The North Carolina Family Doctor, P.A. (The Family Doctor) to release protected health information, if necessary, about the above-named patient to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

I understand that The Family Doctor may need to discuss my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist or other health care provider who is involved in my care.

The Family Doctor may leave messages (for appointment reminders, lab or x-ray results) on my telephone answering machine at my home. __Yes __No

The Family Doctor may leave messages (for appointment reminders, lab or x-ray results) on my telephone voice mail at my work. __Yes __No

I do not currently have a telephone answering machine at home and/or voice mail at work, but if I were to get one, The Family Doctor may leave messages on it. __Yes __No

The Family Doctor may leave messages for appointment reminders with others in my home. __Yes __No

If necessary, The Family Doctor may talk with my spouse or significant other about my medical condition and / or billing information. The name of this person is ____. __Yes __No

If necessary, The Family Doctor may talk with my parents or with my caretaker about my medical condition and / or billing information. The name of my parents or caretaker are: ____. __Yes __No

The Family Doctor **may not** discuss my medical condition with: ______________________________

Rights of the Patient

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to: Administrator, 1728 Fordham Blvd., 151 Rams Plaza, Chapel Hill, NC 27514. I understand that any change in this authorization is effective from the date signed going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

____ ________________________

Signature of Patient, Parent or Guardian Date