



CONSENT FOR RELEASE OF MEDICAL INFORMATION
(Please complete in full or request will be returned to you)

Patient Name: _____ Phone: _____

Address: _____

Social Security # _____ - _____ - _____ Date Of Birth _____ / _____ / _____

I the undersigned, hereby authorize:

The NC Family Doctor, PA
1728 Fordham Blvd. Suite 151 Rams Plaza
Chapel Hill, NC 27514
(919) 968-1985 Fax: (919) 942-0038

To disclose information relating to my medical records to:

Doctor or Facility _____

Address _____

Telephone (_____) _____ Fax (_____) _____

Reason For Disclosure: _____

Records to be released: _____ Complete Chart _____ Specific Dates _____

____ Laboratory Reports _____ Immunization Records _____ Other _____

By signing below, I hereby consent and authorize the release of my medical records, including current and past records. I understand that this authorization includes consent for the release of information relating to my medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected to State and Federal Laws as related to a minor. I agree that a copy of this release shall be valid as this original.

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically 1 year (365) days from the date indicated below.

NOTE: FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION

Signature of Patient or Legal Representative

Relationship to Patient

Witness

Date

You will be notified of any copying fees associated with this request. Records will be sent upon receipt of pre-payment. Please allow 5-7 business days for the processing of these requests. We do not fax medical records