



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:

Doctor or Facility \_\_\_\_\_

Address \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

To disclose information relating to my medical records to:

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

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

Please allow 5-7 business days for the processing of these requests. We do not fax medical records