

**Raleigh Adult Medicine**  
**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
(Print patient's full name)

\_\_\_\_\_  
Birth date (Mo/Day/Yr)

\_\_\_\_\_  
(Street address)

\_\_\_\_\_  
Social security number

\_\_\_\_\_  
(City, state, zip code)

\_\_\_\_\_  
Phone (Home)

At the request of the individual, I \_\_\_\_\_, do hereby authorize \_\_\_\_\_ to release  
(patient's name) (name of facility)

<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> PATHOLOGY REPORTS	<input type="checkbox"/> EMERGENCY REPORTS
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	_____
<input type="checkbox"/> OPERATIVE NOTES	<input type="checkbox"/> ECG/EEG/CARDIAC CATH	_____

From the time period of \_\_\_\_\_ to \_\_\_\_\_

I do  I do NOT authorize release of information related to *AIDS* (Acquired Immunodeficiency Syndrome) or *HIV* (Human Immunodeficiency Virus) Infection, *Psychological* assessment, and treatment for *alcohol* and/or *drug* abuse.

**INFORMATION RELEASE TO:** \_\_\_\_\_  
Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City, state, zip

**PURPOSE OF DISCLOSURE:**

<input type="checkbox"/> REFERRAL TO SPECIALIST	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> WORKERS COMP	<input type="checkbox"/> LEGAL INVESTIGATION
<input type="checkbox"/> DISABILITY DETERMINATION	<input type="checkbox"/> PERSONAL	<input type="checkbox"/> CONTINUING CARE	
<input type="checkbox"/> CHANGE OF DOCTOR (Please give reason)	_____		
<input type="checkbox"/> OTHER (Specify)	_____		

**Please provide current daytime telephone number in the event we need to contact you:** \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
**Signature of individual or guardian or  
Personal Representative of patient s estate**

\_\_\_\_\_  
**Date**

90-411 Record copy fee.

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be 75 cents per page for the first 25 pages, 50 cents per page for pages 26 through 100, and 25 cents for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of \$10.00, inclusive of copying costs. Fee may not exceed \$100.00.