

Pinehurst Medical Clinic ~ 205 Page Road ~ Pinehurst NC 28374
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients 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:
(patients name)

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	_____ OTHER _____
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	_____
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIC CATH	_____

I authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or 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:

REFERRAL TO SPECIALIST _____ INSURANCE _____ WORKERS COMP _____ CHANGE OF DOCTOR

LEGAL INVESTIGATION _____ DISABILITY DETERMINATION _____ PERSONAL _____ CONTINUING CARE
OTHER (SPECIFY) _____

Please provide current 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

MEDICAL INFORMATION RELEASED BY RELEASE OF INFORMATION COORDINATOR

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUNE _____
OP _____ X-Ray _____ OTHER _____
HP _____ PATH _____
NUMBER OF PAGES _____

ROI SPECIALIST

DATE