Sanford Medical Group
Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth _____

Social Security #: _____ Phone # _____

Information Release To:
Sanford Medical Group
555 Carthage St.
Sanford, NC 27330
Phone (919) 774-6518 Fax- (919)774-1831

To:
_____(Name)

_____(Address)

_____ (Phone #) _____ (Fax)

Please Release the following:

_____ Problem List
_____ History/Physical Exam
_____ Immunizations
_____ all records
_____ Progress Notes
_____ Lab Results
_____ all diagnostic testing
_____ _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time expect to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date

_____

Sanford Medical Group Office Use Only

Date request faxed _____ *Initials* _____
Date records received _____ *Initials* _____