3600 NW Cary Pkwy., Suite 104
Cary, North Carolina 27513
Phone: (919) 319-9219 • Fax: (919) 481-1716

Authorization for Release of Protected Health Information

PATIENT

Name (Last, First, MI) _______________ Birthdate _______________

Street Address _______________ City/State/Zip _______________

Home Phone # _______________ Work Phone # _______________ Cell Phone # _______________

RELEASE RECORDS TO:

Name (Clinic, Physician) _______________

Street Address _______________

City/State/Zip _______________

RELEASE RECORDS FROM:

Name (Clinic, Physician) _______________

Street Address _______________

City/State/Zip _______________

WHICH RECORDS ARE TO BE RELEASED? (check all applicable categories):

- ❑ Office Visit Notes
- ❑ OB/Gyn Records
- ❑ Lab Results
- ❑ X-Ray Reports
- ❑ X-Ray Films
- ❑ Hospital Records
- ❑ Records from Specialist
- ❑ Physical Therapy
- ❑ Entire Records
- ❑ Worker's Compensation
- ❑ Other: _______________

Other: _______________

*** All records pertaining to a sensitive nature, such as STD/HIV testing and/or psychiatric/mental health will be released unless indicated here: ❑ **DO NOT release records of a sensitive nature as described above.**

PURPOSE FOR RELEASE:

- ❑ Further Medical Treatment
- ❑ Legal/Attorney Request
- ❑ Application for Insurance
- ❑ Insurance Claim or Payment
- ❑ Change of Clinics
- ❑ Other: _______________

ACKNOWLEDGMENT OF UNDERSTANDING:

- ➢ I understand this authorization is valid for one year unless otherwise noted. Information will NOT be released past the date of signature unless specifically stated: DATE _______________ Initials _______________
- ➢ I understand I may revoke this authorization at any time providing notification in writing, and it will be effective on the date notified except to the extent action has already been taken.
- ➢ I understand there may be a charge incurred for copies of medical records pursuant to NC statute § 90-411 Record Copy Fee.
- ➢ I understand a copy of this authorization will be treated in the same manner as the original.
- ➢ I understand when Preston Medical Associated discloses PHI pursuant to this authorization we can no longer guarantee confidentiality or prevent redisclosure, and the information may no longer be protected by federal privacy rules.
- ➢ I understand by signing this authorization, I agree to allow PMA and all their staff members to disclose the following protected health information to the above stated person(s) or entity.
- ➢ I understand by signing the authorization I agree to all its contents and release PMA from any and all liability resulting from re-disclosure.
- ➢ I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

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Signature (Patient / Legal Representative) **DATE**
(age 18 or over must sign for release of their records)

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AUTHORITY to act on behalf of Patient
(Attach Document)