Clear Form

Print Form

MR #

Horizon Family Medicine, PA
Five Locations With One Purpose . . . Your Health
www.horizonfamilymed.com

410 Canterbury Road	236 Butternut Lane	864 Black Creek Road	213 Barden Street	100 Cunningham Lane, Ste 103
Smithfield, NC 27577	Clayton, NC 27520	Four Oaks, NC 27524	Princeton, NC 27569	Clayton, NC 27527
Phone: (919) 934-5149	Phone: (919) 359-1011	Phone: (919) 963-3148	Phone: (919) 936-5171	Phone: (919) 359-6016
Fax: (919) 934-5632	Fax: (919) 359-9122	Fax: (919) 963-2900	Fax: (919) 936-2328	Fax: (919) 936-2328

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Other Name: _____

Street:_____ City, ST Zip: _____

Date of Birth: _____/_____/_____ Phone: _____ Cell: _____

I authorize the release of medical information as indicated below:

FROM
Practice: _____
Attn: _____
Street: _____
City, ST Zip: _____
Phone: _____
Fax: _____

TO
Practice: _____
Attn: _____
Street: _____
City, ST Zip: _____
Phone: _____
Fax: _____

IF MORE THAN 10 PAGES, PLEASE MAIL RECORDS. DO NOT FAX.

❑ I would like to pick up my records, please call me at the number above.
❑ I would like the records mailed (please indicate the address above).

What to Release: Please choose the records you would like released:

❑ Outpatient note(s)
❑ X-Ray report(s)/film(s)
❑ Laboratory reports(s)
❑ Immunization record
❑ Pathology reports(s)
❑ ALL Medical records
❑ Other, please specify:_____

NOTE: The records listed below have special protection by law. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests	❑ Yes	❑ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	❑ Yes	❑ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	❑ Yes	❑ No/NA

Purpose of the release: Please indicate the reason for this release:

❑ Transfer care
❑ For use in a lawsuit
❑ Follow-up related to an injury
❑ Personal use
❑ To obtain disability
❑ Worker's compensation
❑ Armed Forces requirement
❑ For another doctor
❑ Other, please specify:_____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

❑ Please change the expiration date to last for _____days.

I understand this Authorization can be revoked at any time according to Horizon Family Medicine's privacy practices. This request must be made in writing. Once these records are released, the information is not protected by Horizon Family Medicine and may potentially be re-disclosed by the party who received these records. Horizon Family Medicine, its employees and officers, and attending physicians are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form, and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative AND Relationship to Patient Date

_____ _____
Signature of Witness Date