

- AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION -

Attn: Dr. _____

- Smithfield Clinic HFM-** 410 Canterbury Road, Smithfield, NC 27577, Phone: 919-934-5149, Fax: 919-934-5632
- Clayton Clinic HFM-** 236 Butternut Road, Clayton, NC 27520, Phone: 919-359-1011, Fax: 919-359-9122
- Four Oaks Clinic HFM-** 864 Black Creek Road, Four Oaks, NC 27524, Phone: 919-963-3148, Fax: 919-963-2900
- Riverwood Clinic HFM-** 100 Cunningham Lane, Ste. 103, Clayton, NC 27527, Phone: 919-359-6016, Fax: 919-359-6017

Patient Name: _____ Other Name: _____
 Street: _____ City, State, Zip: _____
 Date of Birth: ____/____/____ Cell : _____ Other phone: _____

I authorize the Release of Medical Information as indicated below:

<p>FROM:</p> <p>Practice: _____</p> <p>Attn: _____</p> <p>Street: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>TO:</p> <p>Practice: _____</p> <p>Attn: _____</p> <p>Street: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>
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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 my records mailed. Please indicate the address above.

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

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Outpatient Note(s) | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Other |
| <input type="checkbox"/> X-Ray Report(s) / Film(s) | <input type="checkbox"/> Pathology Report(s) | Please specify: _____ |
| <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> ALL Medical Records | _____ |

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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Transfer Care | <input type="checkbox"/> Personal use | <input type="checkbox"/> Armed Forces requirement |
| <input type="checkbox"/> For use in a lawsuit | <input type="checkbox"/> To obtain disability | <input type="checkbox"/> For another doctor |
| <input type="checkbox"/> Follow-up related to an injury | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other, please specify: _____ |

Expiration date: This authorization will expire in sixty (60) 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 redisclosed by the party who received these records. Horizon Family Medicine, its employees, officers, and attending physicians/providers 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 <u>AND</u> Relationship to Patient	_____ Date
_____ Signature of Witness	_____ Date

If you have any questions about transferring your records, please contact the Office Coordinator at the Horizon location where you are a patient. Contact information for all Horizon Family Medicine locations is listed at the top of this page.