Chapel Hill Family Medicine
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) (name of facility)

______DISCHARGE SUMMARY ______PATHOLOGY REPORTS ______EMERGENCY REPORTS
______HISTORY & PHYSICAL ______LABORATORY REPORTS ______OTHER________________________
______PROGRESS NOTES ______RADIOLOGY REPORTS ________________________
______OPERATIVE NOTES ______ECG/EEG/CARDIC CATH ________________________

From the time period of ____________________ to ____________________

______ I do ______ I do NOT 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 daytime 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**

PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS WHEN REQUESTED FOR PERSONAL REASONS OR PERMANENT TRANSFER. SMART DOCUMENT SOLUTIONS HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.

MEDICAL INFORMATION RELEASED BY SMART DOCUMENT SOLUTIONS

ENTIRE______ LAB________ EKG__________
DS__________ EKG________ IMMUNE_______
OP__________ X-Ray_______ CLINIC________
HP__________ PATH________ OTHER____________________

____
ROI SPECIALIST DATE

NUMBER OF PAGES ____________