AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO FISCHER CLINIC

Patient's Full Name_____ Date of Birth_____

Street Address _____

City, State, Zip_____

I hereby authorize _____ (office we are requesting information from) to release:

- ☐ my entire medical record
- ☐ selected information _____

for:

- ☐ transfer of care
- ☐ care coordination

Information to be released to:

- ☐ **Dr. Benjamin P. Fischer 919-617-9092 fax**
- ☐ **Dr. Zane I. Lapinskes 919-258-2848 fax**

I hereby authorize disclosure of the health information as indicated on this form. 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 is will not affect any information released prior to notification of cancellation.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Date**

FISCHER CLINIC, PLLC
417 N. Blount Street
Raleigh, NC 27601

Dr. Benjamin Fischer
919-258-2440

Dr. Zane Lapinskes
919-258-2840