AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO FISCHER CLINIC

Patient's Full Name_____ Date of Birth_____

Street Address _____

City, State, Zip_____

I, _____ (patient), do hereby authorize

_____ (office we are requesting information from) to release

- ☐ my entire medical record
- ☐ selected information _____

for the purpose of:

- ☐ transfer of care
- ☐ care coordination

Information to be released to:

FISCHER CLINIC, PLLC
702 N. Person Street
Raleigh, NC 27604
919-258-2440 phone
919-617-9092 fax

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 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**