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 for transfer of care

Information to be released to:

- ☐ **J. Brewer Eberly, MD 919-617-9544 fax**
- ☐ **Benjamin P. Fischer, MD 919-617-9092 fax**
- ☐ **Zane I. Lapinskes, MD 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

Phone Contact:
J. Brewer Eberly, MD 919-258-2443
Benjamin P. Fischer, MD 919-258-2440
Zane I. Lapinskes, MD 919-258-2840