NORTH RALEIGH FAMILY MEDICINE
8331Bandford Way, #101 ♦ Raleigh, NC 27613 ♦ (919) 841- 4566 ♦

AUTHORIZATION FOR REQUEST/RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: ______________________________

BIRTHDATE: _____/_____/_____ SSN: ____________________ DAY-TIME PHONE: ____________________

I HEREBY AUTHORIZE:

____
NAME OF PERSON OR ORGANIZATION RELEASING INFORMATION

____
STREET ADDRESS

____
PHONE NUMBER

____
CITY, STATE, ZIP CODE

____
FAX NUMBER

TO RELEASE INFORMATION TO:

North Raleigh Family Medicine
NAME OF PERSON OR ORGANIZATION TO RECEIVE INFORMATION

8331 Bandford Way, Suite, 101
STREET ADDRESS

919-841-4566
PHONE

Raleigh, NC 27615-1978
CITY STATE ZIP CODE

PLEASE DO NOT FAX RECORDS
FAX

THIS RELEASE LIMITS DISCLOSURE TO: (please check box for requested records)

☐ All / Complete Medical Record or

☐ Lab ☐ X-Ray Reports ☐ Immunizations ☐ Other: ____________________

INFORMATION NOT TO BE RELEASED, IF ANY: ____________________

A specific authorization is required to release information regarding the following: (Please initial the columns if this info.is to be incl.)

	YES	NO	INITIALS
HIV Information	____	____	____
Drug/Alcohol Information	____	____	____
Mental Health Information	____	____	____

THIS INFORMATION IS REQUIRED FOR: (please specify): ____________________

This authorization shall be valid until____________________. Please indicate a date after which no information can be released. If no date is given, consent will be valid for 90 days only.

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

COPY REQUEST: ☐YES ☐NO COPY RECEIVED: ☐YES ☐NO

____________________ / ____________________ ____________________
PATIENT SIGNATURE **PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE** **DATE**

90-411.Record Copy Fee
A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, coping & mailing medical records to the patient or the patient's designed representative. The maximum fee for each request shall be .75/page for the first 25 pages, .50/page for pages 26-100 and .25/ page in excess of 100 pages, provided that the health care provider may impose a minimum fee of $10.00 inclusive of copying costs. Fee may not exceed $100.00