NORTH RALEIGH FAMILY MEDICINE
8331Bandford Way, #101 • Raleigh, NC 27613 • (919) 841- 4566 • Fax: (919) 841-4568

AUTHORIZATION FOR REQUEST/RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: _____

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

I HEREBY AUTHORIZE:

North Raleigh Family Medicine
NAME OF PERSON OR ORGANIZATION RELEASING INFORMATION

8331 Bandford Way, Suite, 101
STREET ADDRESS

919-841-4566
PHONE NUMBER

Raleigh, North Carolina 27615-1978
CITY, STATE, ZIP CODE

919-841-4568
FAX NUMBER

TO RELEASE INFORMATION TO:

_____
NAME OF PERSON OR ORGANIZATION TO RECEIVE INFORMATION

_____
STREET ADDRESS

_____
PHONE

_____
CITY STATE ZIP CODE

_____
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.

_____ / _____ _____

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

90-411.Record Copy FeeA 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