



## Authorization for Release of Medical Records

PRINT PATIENT'S FULL NAME

DOB (Mo/Day/Yr)

PHONE

Street Address

City, State, Zip Code

### Requested Records:

All medical information     Lab results     Progress notes     X-ray / CT / Ultrasound  
 OB care     Operative & Pathology reports     Other \_\_\_\_\_

**PLEASE ONLY SEND THE MOST RECENT VISIT NOTES, SURGERIES & LABS.**

### Send Records To:

MD / Practice Name: \_\_\_\_\_

### Copy Records From:

MD / Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Purpose of Disclosure:

Referral to Specialist     Insurance     Transfer of care     Legal Investigation  
 Disability Determination     Second Opinion     Coordination of care     Other \_\_\_\_\_

I UNDERSTAND AND ACKNOWLEDGE THAT THE RECORDS MAY INCLUDE ALCOHOL/DRUG, MENTAL HEALTH, OR HIV/AIDS INFORMATION.

I understand that I may revoke this authorization at any time, in writing, and that such revocation will not affect information that has already been released.

Unless otherwise noted, this authorization will expire six months from the date on which it was signed.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**Processing this request will require a minimum of 7-10 business days.**

Date Completed: \_\_\_\_\_ Signature: \_\_\_\_\_

Faxed: \_\_\_\_\_ Mailed: \_\_\_\_\_ Picked up: \_\_\_\_\_

This release contains confidential information. If you are not the intended recipient of this release or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any distribution or copying of this fax is strictly prohibited. If you have received this release in error, please notify us by telephone.

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