AUTHORIZATION TO RELEASE INFORMATION

INSTRUCTIONS FOR COMPLETING FORM: Please write legibly and complete all sections indicated. Return the completed and signed form to: Printed Patient Name:	MR#:
Patient Address:	Birth Date:
Patient Telephone:	SSN#:
Date(s) of Treatment Under Request:	( ) Mail ( ) Pick-up

I hereby authorize ( ) ____ to release copies of records on the above patient to: ( ) Myself ( ) Other (Please complete below.)

Name: Moore Family Medicine	Address: 304 Saunders Street Carthage, NC 28327
Phone: 910.947.3000	Fax: 910.947.6798

INFORMATION TO BE RELEASED INCLUDES: (Check all applicable and indicate other information in the spaces below. Please also be aware that you may be charged for any records copied.)

( ) Clinic Visit Notes (Encounters and Procedures)
( ) X-ray Films
( ) Operative Report(s)
( ) History and Physical
( ) Other:____
( ) Laboratory Report(s)
( ) X-ray Report(s)
( ) Pathology Report(s)
( ) Discharge Summary
( ) EKG Report(s)
( ) Emergency Room Record(s)
( ) Consultation Report(s)
( ) Complete Record

BY INITIALING BELOW, I further authorize release of information that may be present in my record to include information related to:

( ) Alcohol or Drug Abuse	( ) Mental or Behavioral Health or Psychiatric Care
( ) AIDS and/or HIV Diagnosis	( ) Psychotherapy Session Notes and Records

PURPOSE OF RELEASE: I understand that this authorization is voluntary and that I may refuse to sign it. I need not sign this form to ensure healthcare treatment or payment for such treatment. This authorization is void 180 days after the date signed or anytime I, as the patient, guardian, or legally authorized representative make a specific written request to the entity noted above to revoke the authorization. Such revocation shall be effective except to the extent that the facility has already used or disclosed information in reliance on the authorization. I understand that once information is used or disclosed based on this authorization it may be re-disclosed by the recipient and at such time may no longer be protected by federal privacy laws or regulations.

Signature of Patient: ***Individual With Legal Authority to Sign:	Date:
Signature of Witness:	Date:

*****THE FOLLOWING INFORMATION MUST BE COMPLETED WHENEVER THE PATIENT IS UNABLE TO PERSONALLY SIGN FOR RELEASE OF PROTECTED INFORMATION.** Patient is unable to authorize release of records/information as a result of the following (check one):

( ) Patient is a minor	( ) Patient is mentally incompetent
( ) Patient has a physical disability that prohibits signing	( ) Deceased
( ) Other (clearly state reason)	

NOTE: If the patient is deceased, only the executor and/or administrator of the estate or next-of-kin may authorize release of copies of medical records. Documentation reflecting such individuals' legal authority to sign for release of records must be provided.