

Cary Healthcare Associates, P.A.
212 Ashville Avenue • Suite 30 • Cary, NC 27511
(919) 233-6000 • Fax: (919) 233-6052

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patient's full name)

Birth Date (Mo/Day/Yr)

(Street Address)

Social Security Number

(City, State, Zip code)

Phone (Daytime)

At the request of the individual, I _____ do hereby authorize
(Patient's name)

CARY HEALTHCARE ASSOCIATES, P.A. to release the following:

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Records Received from Previous
<input type="checkbox"/> Specialist Correspondence	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Primary Care Physician(s)
<input type="checkbox"/> Hospital Reports	<input type="checkbox"/> EKG	
<input type="checkbox"/> Other _____		

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO:

Name of Company/Agency/Facility/Person

Street address

City, State, Zip

Telephone

Fax

PURPOSE OF DISCLOSURE:

<input type="checkbox"/> Change of Doctor	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal Investigation
<input type="checkbox"/> Referral to specialist	<input type="checkbox"/> Personal	<input type="checkbox"/> Workers Comp
<input type="checkbox"/> Other _____		

This authorization shall be in force and effect until _____ at which time this authorization expires.
(maximum 1 year)

I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or
Personal Representative of patient's estate

Date

NOTE: Currently, the record copy fee is \$0.50 per page for pages 1-25, \$0.25 per page for pages 26-100, and \$0.10 per page for pages over 100. For further information on pricing contact Medical Records at (919) 233-6000.