

Cary Healthcare Associates, P.A.
222 Ashville Avenue • Suite 10 • Cary, NC 27518
(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.