CARY HEALTHCARE ASSOCIATES, P.A.
222 ASHVILLE AVENUE, SUITE 10, CARY, NC 27518
(919) 233-6000 FAX: (919) 233-6052

AUTHORIZATION TO RECEIVE MEDICAL INFORMATION

_____ _____
Print Patient's Full Name Birth Date (Month/Day/Year)

_____
Street Address

_____ _____
City, State, Zip Code Phone (Daytime)

At the request of the individual, I _____, do hereby authorize

_____
Name of Company/Doctor's Office

_____
Street Address City, State, Zip Code

_____
Telephone Fax number

TO RELEASE THE FOLLOWING:

_____Progress Notes	_____Laboratory Reports	_____Transferred Records
_____Specialist Correspondence	_____Radiology Reports	
_____Hospital Reports	_____EKG	
_____Other		

_____I do _____ I do not authorize the release of information related to AIDS or HIV, psychiatric and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: **CARY HEALTHCARE ASSOCIATES, P.A.**
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PURPOSE OF DISCLOSURE:

_____Change of Doctor	_____Insurance	_____Legal Investigation
_____ Referral to specialist	_____Personal	_____Workers Comp
_____Other_____		

This authorization shall be in force and effect until_____ at which time this authorization expires.

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

_____ _____
Signature of Individual or Guardian Date

NOTE: A processing fee may be charged. By law, maximum record copy fee is $ 0.75 per page for pages 1-25, $ 0.50 per pages 26-100 and $0.25 per pages over 100.