

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

AUTHORIZATION TO RELEASE 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

INFORMATION FROM:

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

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.

RELEASE INFORMATION TO:

Name of Company/Doctor's Office

Street Address

City, State, Zip Code

Telephone

Fax number

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.