CARY INTERNAL MEDICINE & THE DIABETES CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____

PRINT PATIENTS FULL NAME | DATE OF BIRTH (Mo/Day/ Yr)

_____ _____

STREET ADDRESS | SOCIAL SECURITY NUMBER

_____ _____

CITY, STATE, ZIP CODE | PHONE NUMBER

At the request of the individual, I_____, do hereby authorize_____ to release:
PRINT NAME NAME OF FACILITY

DATES OF_____

_____DISCHARGE SUMMART _____PATHOLOGY REPORTS _____EMERGENCY REPORTS ____HISTORY & PHYSICAL ____LABORATORY REPORTS
_____PROGRESS NOTES _____RADIOLOGY REPORTS _____OPERATIVE NOTES ____ECG/EEG/CARDIAC CATH
_____OTHER _____

_____I DO _____ I DO NOT AURTHORIZE THE RELEASE OF INFORMATION RELATED TO AIDS (ACQUIRED IMMUNO-DEFICIENCY SYNDROME) OF HIV (HUMAN IMMUNODEFICIENCY VIRUS) INFECTION, PSYCHIATRIC CARE AND/OR PSYCHOLOGICAL ASSESSMENT, AND TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE.

INFORMATION RELEASE TO: _____
NAME OF COMPANY/AGENCY/FACILITY/PERSON

_____
STREET ADDRESS

_____
CITY, STATE, ZIP

PURPOSE OF DISCLOSURE:

____REFERRAL TO SPECIAL _____INSURANCE _____WORKERS COMP _____LEGAL INVESTIGATION ____DISABILITY DETERMINATION
____PERSONAL _____CONTINUED CARE _____ CHANGE OF DOCTOR
OTHER (SPECIFY)_____

PLEASE PROVIDE CURRENT TELEPHONE NUMBER IN THE EVENT WE NEED TO CONTACT YOU:_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect 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 and would then no longer be protected by federal regulations.

_____ _____

SIGNATUR OF INDIVIDUAL OR GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE | **DATE**

NOTE: THERE WILL BE A CHARGE FOR A PERSONAL COPY OR THE PERMANENT TRANSFER OF YOUR RECORD. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE_____ LAB_____ EKG_____
DS_____ IMMUNE_____
OP_____ XRAY_____ HP_____
PATH_____ OTHER_____
_____

ROI SPECIALIST_____
DATE_____