CAROLINAS URGENT and PRIMARY CARE

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
Telephone #: _____

AUTHORIZATION:

I hereby authorize Carolinas Urgent and Primary Care to receive/release/disclose the above named individual's health information:

Release From:	**Release To:**
Name:_____	Name: Carolinas Urgent and Primary Care
Address:_____	Address: 4370 Arendell St. Suite A
_____	Morehead City, NC 28557
Phone: ( ) _____	Phone: (252) 222-0204
Fax: ( )_____	Fax: (252) 222-0433

Information to be released/ disclosed:

Entire Health Record _____Office Visits _____ Reports (Labs, X-Ray, etc) _____
Medications _____ Immunization Record _____
Specific Dates of Service: _____
Please produce records via: Mail _____Fax _____ Pick Up _____

Purpose:

Continuity of Medical Care _____Disability _____ Moving out of the area _____
Insurance or Other Third Party Reimbursement _____ Pending Legal Action _____
Other (Specify) _____

I understand that the information in my medical record may include information relating to sexually transmitted disease and/or acquired immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above. A fee will be associated with copying/printing documentation from your medical record for personal use.

Restrictions:

According to the Federal and State regulations, if the medical information requested relates to AIDS/ HIV treatment or treatment in a federally recognized chemical dependency unit then the information will be accompanied with a statement limiting disclosure to third parties as required by law.

I realize that although the Carolinas Urgent and Primary Care has the responsibility to maintain the confidentiality of the medical records in its possession, I understand that once the information is disclosed the recipient may redisclose it and federal privacy laws or regulations may not protect the information. Carolinas Urgent and Primary Care will not be held responsible for any subsequent disclosure by the recipient of the health information. I release the Carolinas Urgent and Primary Care of any liability, which may arise as a result of any subsequent disclosure of my personal health information by the recipient.

I have read and understand the Carolinas Urgent and Primary Care's policy on releasing my personal health information.

Duration:

This authorization will remain valid until _____. I understand that I have a right to revoke this authorization at any time by submitting a written revocation to Carolinas Urgent and Primary Care.

SIGNATURE

Patient Signature: _____ Date: _____
Personal/ Legal Representative Signature: _____
If signed by Personal/ Legal Representative, relationship to Patient: _____
Carolinas Urgent and Primary Care Representative: _____
Date: _____