Hometown Direct Primary Care

332 N. Bright Leaf Blvd, Suite C
Smithfield, NC 27577
Phone (919) 901-7344 Fax (319) 250-7453

Medical Records Release Form

Patient Name: _____ DOB: _____

Address: _____

Parent/Guardian/Responsible party* (if applicable): _____
*This person must match information provided on the Patient Information Form.

Please give name and address of medical facility you are authorizing your medical records to be released from:

Physician/Clinic: _____

Address:_____ City/State/Zip: _____

Phone: _____ Fax: _____

I authorize my medical records be released to (BY FAX):

Physician/Clinic/Person: _____

Address:_____ City/State/Zip: _____

Phone: _____ Fax: _____

Check all records to be released:

□ All medical records □ Lab/Test Results □ Billing Information

□ Mental Health records □ HIV/AIDS tests/results □ Drug/alcohol use/abuse

□ Other _____

Limitations of records to be released: □ None or □ Other _____

Specific dates of records requested (last 3 years unless otherwise noted): _____

Purpose of records being released:

□ Continuity of care □ Personal copy □ Insurance claim

□ Legal claim □ Disability claim □ Other _____

I understand that:

- I may refuse to sign this authorization and that my refusal has no impact on receiving treatment.
- I can inspect any information disclosed under this agreement.
- My signing this document is voluntary.
- I can revoke this authorization at any time in writing, except to extent this authorization has already been acted upon.
- I can receive a copy of this authorization.
- This authorization expires 6 months from the date it is signed unless otherwise noted.

Signature: _____ Date: _____