

East Cary Family Physicians
103 Parkway Office, Ste 104, Cary NC 27518
Phone: (919) 200-6587 Fax (919) 460-2016

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____

Date of Birth: _____ Medical record number: _____

I hereby authorize the medical staff of East Cary Family Physicians to disclose my protected health information as described below:

1. I am authorizing the disclosure or sharing of my protected health information to:

Facility / Physician's Name, Other: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Fax Number: (____) _____

2. The specific protected health information I am disclosing is:

- Complete medical record
- Information about alcohol or substance abuse
- Information about sexually transmitted diseases including HIV/AIDS
- Information about mental health

3. I understand that I may revoke this authorization at any time by notifying you in writing of my desire to revoke the authorization. However, I understand that any action already taken on reliance of this authorization cannot be reversed, and my revocation will not affect those actions.

4. This authorization expires on _____, or sooner if I revoke it in writing as stated above, or upon the occurrence of the following expiration event noted below for which this disclosure was authorized:

(Date)

(Signature of Patient)

(Date)

(Signature of Patient's Guardian or Personal Representative)