East Cary Family Physicians

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Gunjan Nigam, MD

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)