East Cary Family Physicians

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Gunjan Nigam, MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____

Date of Birth:_____ Social Security Number: _____

I hereby request that my protected health information, as described below, be released to East Cary Family Physicians, for the purpose of ongoing treatment.

1. I am authorizing the disclosure of my protected health information from:

Facility / Physician Name:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: (____)_____

2. The specific protected health information I am requesting to be disclosed is:

☐ Medical records (last 2 progress notes, recent blood work, all diagnostic imaging reports)

☐ Information about alcohol or substance abuse

☐ Information about sexually transmitted diseases including HIV/AIDS

☐ Information about mental health

3. I understand that my protected health information may be incorporated into my medical record at East Cary Family Physicians and will become part of my protected health information at East Cary Family Physicians.

4. This authorization expires on _____, or in 90 days if no date is indicated, or sooner if I revoke it in writing, 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)