Authorization to Release Medical Information

Tri-City Family Medicine and Urgent Care Clinic, PLLC
107 Hyannis Drive
Holly Springs, NC 27540-8327
Office: 919-363-8666
Facsimile: 919-363-8668

DATE: _____

RECORDS FROM: _____

_____

_____

RECORDS TO: TRICITY FAMILY MEDICINE AND URGENT CARE CLINIC
107 HYANNIS DR
HOLLY SPRINGS NC 27540

____I request a copy of my complete medical record. **(PLEASE DO NOT FAX, MAIL ONLY)**
____I request only the medical records from the time period _____ to _____.

PURPOSE OF RELEASE: _____

Patients Name: _____

Date of Birth: _____

Patients Signature _____

Witnessed by: _____

AUTHORIZATION FOR USE OF DISCLOSURE PROTECTED HEALTH INFORMATION

I, _____, the above identified patient, or my legal representative, hereby authorizes use of disclosure of protected health information to/from TRI-CITY FAMILY MEDICINE & URGENT CARE CLINIC, PLLC including all records, x-rays, abstract and excerpt of all records, mental health records and/or evaluations and any other information which you may posses relating to the examination, diagnosis, prognosis, care & treatment, billing or opinion rendered concerning any and all conditions that the above identified PATIENT has had in the past, may have now & in the future. I understand that the information used or disclosed may be subject to re-disclosure by TRI-CITY FAMILY MEDICINE & URGENT CARE CLINIC, PLLC and would then no longer be protected by federal privacy regulations.