Tricity Family Medicine & Urgent Care Clinic, PLLC

107 Hyannis Dr., Holly Spring, NC 27540
Ph: 919-363-8666 Fax: 919-363-8668

Authorization for Release Of Medical Information

PATIENT'S NAME:

DATE OF BIRTH: (MM/DD/YYYY)

ADDRESS:

PATIENT'S PHONE# :

DATE OF REQUEST:

DATE NEEDED:

STAFF WITNESSED NAME:

SIGNATURE & DATE:

OR

☐ I authorize Tricity Family Medicine & Urgent Care Clinic to release information to:

NAME OF PROVIDER OR FACILITY

ADDRESS

CITY STATE ZIP CODE

ZIP

PHONE #/FAX # (INCLUDE AREA CODE)

☐ I authorize Tricity Family Medicine & Urgent Care Clinic to obtain information from:

NAME OF PROVIDER OR FACILITY

ADDRESS

CITY STATE ZIP CODE

ZIP

PHONE #/FAX # (INCLUDE AREA CODE)

PURPOSE FOR THIS REQUEST (Check one)

☐ Transfer of Care ☐ Continuity of Care ☐ Other

TYPE OF RECORDS REQUESTED (Check one)

☐ Immunization History ☐ Laboratory test results ☐ X-ray reports Date(s) of treatment

☐ All medical records related to a specific illness or injury. Specify illness/injury Date(s) of treatment

☐ Complete Medical Records

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.

☐ One year from the date of this authorization **OR** Date(s) of treatment .(insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any **future** treatment of the type described above until: Insert Date

I understand that:

My right to healthcare treatment is not conditioned on this authorization.
I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations the information stated above could be redisclosed.
Release of HIV-related information mental health related care or substance abuse diagnosis and treatment information requires additional authorization.
There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative

Date

Relationship to Patient (if requester is not the patient)