Horizon Family Medicine, PA

MR#

- AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION -

Attn: Dr. ______________________________

☐ Clayton Clinic HFM- 236 Butternut Road, Clayton, NC 27520, Phone: 919-359-1011, Fax: 919-205-1473
☐ Four Oaks Clinic HFM- 864 Black Creek Road, Four Oaks, NC 27524, Phone: 919-963-3148, Fax: 919-963-2900
☐ Riverwood Clinic HFM- 100 Cunningham Lane, Ste. 103, Clayton, NC 27527, Phone: 919-359-6016, Fax: 919-359-6017

Patient Name: ______________________________ Other Name: ______________________
Street: ______________________________ City, State, Zip: ______________________
Date of Birth: ______/______/______ Cell : ______________________ Other phone: ______________________

I authorize the Release of Medical Information as indicated below:

FROM:
Practice: ______________________________
Attn: ______________________________
Street: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________

TO:
Practice: ______________________________
Attn: ______________________________
Street: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________

IF MORE THAN 10 PAGES, PLEASE MAIL RECORDS. DO NOT FAX.

☐ I would like to pick up my records. Please call me at the number above.
☐ I would like my records mailed. Please indicate the address above.

What to release: Please choose the records you would like released:

☐ Outpatient Note(s)
☐ X-Ray Report(s) / Film(s)
☐ Laboratory Report(s)
☐ Immunization Record
☐ Pathology Report(s)
☐ ALL Medical Records
☐ Other
Please specify: ______________________________
____

NOTE: The records listed below have special protection by law. I authorize the release of information pertaining to:

- The diagnosis or treatment of AIDS, including results of HIV tests ☐ Yes ☐ No/NA
- The diagnosis or treatment of drug and/or alcohol abuse ☐ Yes ☐ No/NA
- The treatment and/or consultation for mental health or psychiatric disorders ☐ Yes ☐ No/NA

Purpose of the release- please indicate the reason for this release:

☐ Transfer Care
☐ For use in a lawsuit
☐ Follow-up related to an injury
☐ Personal use
☐ To obtain disability
☐ Worker's Compensation
☐ Armed Forces requirement
☐ For another doctor
☐ Other, please specify: ______________________

Expiration date: This authorization will expire in sixty (60) days unless otherwise indicated below:

☐ Please change the expiration date to last for ______________ days.

I understand this Authorization can be revoked at any time according to Horizon Family Medicine's privacy practices. This request must be made in writing. Once these records are released, the information is not protected by Horizon Family Medicine and may potentially be redisclosed by the party who received these records. Horizon Family Medicine, its employees, officers, and attending physicians/providers are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form, and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

______________________________ ______________
✍Signature of Patient Date

______________________________ ______________
✍Signature of Legal Representative AND Relationship to Patient Date

______________________________ ______________
✍Signature of Witness Date

If you have any questions about transferring your records, please contact the Office Coordinator at the Horizon location where you are a patient. Contact information for all Horizon Family Medicine locations is listed at the top of this page.