West Cary Family Physicians
256 Towne Village Dr, Cary NC 27513-8910
Phone: (919) 460-2015 Fax (919) 460-2016

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____

Date of Birth: _____ Medical record number: _____

I hereby authorize the medical staff of West 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 (check all appropriate boxes):

☐ Office visit notes (last 2 progress notes only)

☐ Laboratory reports

☐ Radiology reports

☐ Immunization records

☐ Other:_____

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)