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:_____ Social Security Number: _____

I hereby request that my protected health information, as described below, be released to West 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 (check all appropriate boxes):

☐ Office visit notes (last 2 progress notes only)

☐ Laboratory reports

☐ Radiology reports

☐ Immunization records

☐ Other:_____

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