

Albemarle Gastroenterology Associates, P.C

Authorization to Release Medical Records:

PATIENT INFORMATION:

Name (print) \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

INFORMATION TO BE RELEASED FROM:

Name of facility or provider \_\_\_\_\_
Address \_\_\_\_\_

INFORMATION TO BE SENT TO:

Name of designated recipient \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Release to active my chart account: Yes \_\_\_\_\_ No \_\_\_\_\_ Initials \_\_\_\_\_

INFORMATION TO BE RELEASED: (check one)

\_\_\_\_\_ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
\_\_\_\_\_ All medical records
\_\_\_\_\_ Specific information (please specify) :

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

\_\_\_\_\_ Attorney \_\_\_\_\_ Insurance \_\_\_\_\_ Doctor \_\_\_\_\_ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

\* EXCLUDE the following information from the records released (please initial)

\_\_\_\_\_ Drug / Alcohol abuse/treatment & diagnosis \_\_\_\_\_ Sexually transmitted disease
\_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing \_\_\_\_\_ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
(Patient, guardian\*, or Authorized representative\*)

This authorization will expire 90 days from the date signed
Possible copying fee required

Please fax this completed form to: 1-252-335-9498 or mail to:
Albemarle Gastroenterology Assoc. 405 Hastings Ln, Elizabeth City, NC 27909

If you have questions regarding your request, please call: 1-252-335-5588 (please allow
48 hours for your request to be received and entered into our system before calling)