

# Chapel Hill Doctors Integrative Health Center

55 Vilcom Center, Suite 110, Chapel Hill, NC 27514 Phone: 919-929-7990 Fax: 919-929-7991

## Medical Information Release Form

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

I, \_\_\_\_\_, the patient/guardian/healthcare power of attorney,  
authorize **Chapel Hill Doctors to** (circle one)

\_\_\_ receive medical and other information from:

\_\_\_ release medical and other information to:

**Individual Name or Practice (required):**

\_\_\_\_\_

**Phone (required):** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Specify Email or Street Address\*:** \_\_\_\_\_

**City (required):** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**\*There is a charge for printed records.** If records are being requested to be sent to a lawyer, insurance or workers compensation company, please have them contact us with a written request; otherwise the patient will be charged per North Carolina General Statutes 90-411: printed Records Medical Record charges inclusive of searching, handling, copying, and mailing costs are:  
\$.75/page for first 25 pages    \$.50/page for pages 26-100    \$.25/page for pages over 100    Minimum fee of \$10.00 permitted

**TREATMENT DATES TO BE DISCLOSED:**  Entire  Year to Date  Other \_\_\_\_\_

**PURPOSE OF THE DISCLOSURE:**  Insurance  Legal  Continuing Care  Personal  Other (specify)

**SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:**

History and Physicals     Progress Notes     Hospital     Correspondence  
 Labs and X-rays     Insurance     Miscellaneous     All

**SPECIFIC INFORMATION TO NOT BE DISCLOSED:** \_\_\_\_\_

*I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the Chapel Hill Integrative Health Center. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.*

*I hereby authorize Chapel Hill Integrative Health Center to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.*

*I hereby release Chapel Hill Integrative Health Center from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.*

*This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.*

\_\_\_\_\_  
**PATIENT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**WITNESS**

\_\_\_\_\_  
**DATE**