ChapelHILL Primary Care

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Medical Information Release Form

Patient:_____Date of Birth:_____Patient Phone#: _____

I, _____, the patient/guardian/healthcare power of attorney (circle one), authorize Chapel Hill Doctors Healthcare Center to:

❏ **Receive** medical and other information from: _____
or
❏ **Release** medical and other information to:_____

Individual Name or Practice (Required)*: _____

Phone (required): _____Fax:_____

Specify Email or Street Address:_____

City (Requred): _____State: _____Zip: _____

*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 Statues 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

I would like records sent from the following doctors: (Please write names)

_____or ❏ All of my doctors

Treatment dates to be disclosed: ❏ Entire ❏ Year to date ❏ Other _____

Purpose of the disclosure: ❏ Insurance ❏ Legal ❏ Continuing Care ❏ Personal ❏ Other _____

Specific description of the information to be disclosed:

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

Specific information **NOT** to be released: _____

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 one 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 Doctors Healthcare 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 Healthcare 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 Healthcare 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: