Cape Fear Center for Digestive Diseases, PA

PO Box 87388, Fayetteville, NC 28304 910-323-2477 ext. 2503

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____

(Print patients full name) Birth date (Mo/Day/Yr)

_____ _____

(Street address) Social security number

_____ _____

(City, state, zip code) Phone (Home)

I _____, do hereby authorize _____ to release:

Print Patient's Name

_____DISCHARGE SUMMARY _____PATHOLOGY REPORTS _____EMERGENCY REPORTS
_____HISTORY & PHYSICAL _____LABORATORY REPORTS _____OTHER_____
_____PROGRESS NOTES _____RADIOLOGY REPORTS _____
_____OPERATIVE NOTES _____ECG/EEG/CARDIAC CATH _____

Please check one: _____ I do _____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO:_____

Name of Company/Agency/Facility/Person

_____

Street address

_____

City, state, zip

Fax: 910-323-1913

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL _____CONTINUING CARE
_____OTHER (SPECIFY)_____

Please provide current telephone number in the event we need to contact you: _____

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment at Cape Fear Center for Digestive Diseases, PA. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization is valid for 12 months from the date of signature. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

_____ _____

Signature of patient or guardian **Relationship** **Date**

MEDICAL INFORMATION RELEASED BY MEDICAL RECORDS SPECIALIST

ENTIRE_____ LAB_____ EKG_____
DS_____ EKG_____ IMMUNE_____ _____
OP_____ X-ray_____ OTHER_____ Staff signature
HP_____ PATH_____ _____ _____
NUMBER OF PAGES_____ _____ Date

APPROPRIATE FEES MAY BE CHARGED FOR THE COPYING OF PATIENT RECORDS AND WILL BE THE RESPONSIBILITY OF THE PATIENT.