Capital Family Physicians, P.A.

2417 Atrium Drive, Suite 201, Raleigh, NC 27607 Ph: (919) 232-0020 Fax: (919) 232-0030

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Last Name First MI SSN Date of Birth (mm/dd/yyyy)

Street Address City State Zip

Daytime Telephone Numbers in the event we need to contact you: (_____)_____(_____)_____
Area Code & Phone Numbers

At the request of the individual, I _____, do hereby authorize_____to release:
(Patient's Name) (Name of Facility)

____Discharge Summary ____Pathology Reports ____Emergency Reports
____History and Physical ____Laboratory Reports ____Other _____
____Progress Notes ____Radiology Reports _____
____Operative Notes ____ECG/EEG/Cardiac Cath _____

From the time period of _____ to _____

____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...

INFORMATION RELEASE TO:

_____
Name of Company / Agency / Facility / Person

_____
Street Address

_____
City, State, Zip Phone / Fax #'s

INFORMATION RELEASE FROM:

_____
Name of Company / Agency / Facility / Person

_____
Street Address

_____
City, State, Zip Phone / Fax #'s

PURPOSE OF DISCLOSURE:

____Referral to Specialist ____Insurance ____Workers Comp
____Legal Investigation ____Disability Determination ____ Personal
____Change of Doctor ____ Continuing Care ____Other _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual or Guardian or Personal Representative of Patient's Estate Date

Please note: There is a charge for medical records when requested for personal reasons or permanent transfer. Smart Document Solutions has been contracted to provide this service and will invoice you directly. Questions maybe directed to 1-800-464-0035.

MEDICAL INFORMATION RELEASED BY SMART DOCUMENT SOLUTIONS

ENTIRE_____ LAB_____ EKG_____
DS_____ IMMUNE_____ OP_____
OP_____ X-RAY_____ CLINIC_____
HP_____ PATH_____ OTHER_____

_____
ROI SPECIALIST DATE

NUMBER OF PAGES_____