Raleigh Gynecology & Wellness, PA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____

Social Security No. _____ Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Birth Date: (Mo/Day/Yr) _____

At the request of the individual, I _____ , do hereby authorize
Patient's Name

_____ to release:

____ PROGRESS NOTES ____ PATHOLOGY REPORTS ____ ALL RECORDS

____ OTHER DOCTORS NOTES ____ LABORATORY REPORTS ____ OTHER _____

____ OB/GYN NOTES ____ RADIOLOGY REPORTS _____

____ HOSPITAL NOTES ____ ECG/EEG/CARDIAC CATH _____

____ 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 (Physician, Hospital, Agency, etc.)

_____
Street Address

_____
City, State, ZIP

PURPOSE OF DISCLOSURE:

____ REFERRAL TO SPECIALIST ____ INSURANCE ____WORKERS COMP

____ LEGAL INVESTIGATION ____ DISABILITY DETERMINATION ____ PERSONAL

OTHER (Please specify): _____

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 affect any information released prior to notification 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

Reason for transferring: _____

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

NOTE: There will be a charge for record in accodance with the $0.75 per page for pages 1-25, additional $0.50 per page from pages 26 through 100, and an additional $0.25 per page from pages 101 and beyond + Actual Postage. Healthport has been contracted to provide this service and will invoice you directly with pre bill invoice. Once invoice has been paid the medical records will be print and mailed.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____ LAB _____ mammogram _____

IMM _____ EKG_____ number of pages _____

PN _____ X-ray _____ other _____

PL/MEDS _____ Path _____ _____

_____
HEALTHPORT ROI SPECIALIST

_____
DATE