ARDMORE FAMILY PRACTICE
2805 Lyndhurst Ave
Winston-Salem, NC 27103
(336) 659-0076 Phone (336) 659-0272 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

(Street address) _____ Phone (Home) _____

(City, state, zip code) _____

At the request of the individual, I _____, do hereby authorize the release of:
(Patients name)

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

_____ 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

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL 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 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**

NOTE: **HealthPort has been contracted to provide the service of processing medical records request. Currently, the charge is $0.75 (1-25 per page), $0.50 (26-100 per page), and $0.25 (101+ per page) plus actual postage. Prices are subject to change without notice. For further information on pricing, please contact HealthPort 1-877-595-9900**

MEDICAL INFORMATION RELEASED BY HEALTHPORT

Entire_____ X-Ray / MRI_____ Pathology_____
HP_____ EKG / Echo_____
Lab_____ Immunizations_____ OTHER_____

_____ _____
ROI SPECIALIST DATE