



**FAMILY MEDICAL ASSOCIATES OF RALEIGH**

**3500 Bush Street, Suite 103**

**Raleigh, NC 27609**

**Phone: 919-875-8150 Fax: 919-875-9577**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

*\* 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.*

**(Please Print)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mailing Address: \_\_\_\_\_ City / State / Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Requesting records from/send to: \_\_\_\_\_

Mailing address line 1: \_\_\_\_\_ Mailing address line 2: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Purpose of request:  Continuing care  Referral to specialist  Insurance  Legal Investigation  Change of doctor  Personal

I do  I do NOT authorize release of information related to AIDS or HIV infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**Records Requested –Check All That Apply**

For the time period of: \_\_\_\_\_ to \_\_\_\_\_

- HOSPITAL/ ER NOTES (DOS: \_\_\_\_\_)  PROGRESS NOTES  EKG REPORTS  PATHOLOGY REPORTS
- SURGICAL REPORTS  LAB RESULTS  RADIOLOGY REPORTS (Site requested: \_\_\_\_\_)
- 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 furnished may not condition its treatment of me on whether or not I sign the authorization.*

\_\_\_\_\_  
**Signature of individual/guardian/personal rep.**

\_\_\_\_\_  
**Date**

**Office Use Only:**

Received by: \_\_\_\_\_  
Staff Signature (Witness) \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by Administration (local transfers only): \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Processed by (ID verified): \_\_\_\_\_  
Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*File or Scan to Patient Chart\*\***