Family Medical Associates of Raleigh
Your Family Comes First

3500 Bush Street
Raleigh, NC 27609
F: 919.875.9577
P: 919.875.8150
www.fmaraleigh.com

MEDICAL RECORDS RELEASE AUTHORIZATION

MRN: _____
Updated 07/19/2018

**** According to the NC statute (§ 90-411. Record copy fee.); there is a charge for medical records when requested for any reason except, "Referral to specialist". ProviderFlow has been contracted to provide this service and will invoice you directly.***

All fields are required and must be complete or this request may be rejected.

Patient Name: _____ DOB: _____/_____/_____

Mailing Address: _____City / State / Zip: _____

Daytime Phone: _____-_____-_____

o Requesting records ***from*:** _____

o Requesting records ***sent to*:** _____

Mailing address line 1: _____ Mailing address line 2:_____

City / State / Zip: _____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

Purpose of request: □ □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 –Circle All That Apply

PROGRESS NOTES –** ***LAST THREE YEARS UNLESS OTHERWISE SPECIFIED BELOW*** **

HOSPITAL/ ER NOTES (DOS: _____) □□ EKG REPORTS □ PATHOLOGY REPORTS □ SURGICAL REPORTS

LAB RESULTS □ RADIOLOGY REPORTS (Site requested: _____)

Other _____

For the time period of: _____ to _____

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/legal representative **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

****Scan to Patient Chart****