CAPE FEAR FAMILY MEDICAL CARE
405 Owen Drive
Fayetteville, NC 28304
Ph: (910) 323-3183
Fax: (910) 745-8478

MED ONE ENDOCRINOLOGY
405 Owen Drive
Fayetteville, NC 28304
Ph: (910) 401-5425
Fax: 910-401-5420

MED ONE CARE
413 Owen Drive
Fayetteville, NC 28304
Ph: (910) 401-5688
Fax: (910) 745-8478

By signing this authorization, I authorize my Health Care Provider to disclose my protected health information. Please allow up to 30 days for records to be completed. There will be a flat $10 fee for medical records on disks. Medical records on paper are charged per page.

Patient's Full Name: **DOB:** Fee Due_____

Address:

Authorization to Disclose Protected Health Information

RELEASE INFORMATION **FROM**: Specify Provider/Organization Name	RELEASE INFORMATION **TO**: Specify Provider/Organization Name
_____	_____
_____	_____
_____	_____
_____	_____

Covering the periods of health care: From (**Date**) ___/___/___ **to** ___/___/___

Information authorized for disclosure:

___ **Complete Health Record**	___ **Immunization Records**	___ **Laboratory Reports**
___ **Visit / Discharge Summary**	___ **Progress Reports**	___ **Other**
___ **Physical**	___ **Radiology / Diagnostic**	_____
___ **Pathology Reports**	___**Imaging**	_____

I authorize the release of parts of the record that relate to substance abuse, psychological/psychiatric condition, and or communicable diseases including (aids), or test for infection (HIV) if present____

The purpose for which disclosure is authorized: ___ Medical Care Legal ___
Other _____
_____

I understand I have a right to revoke this authorization at any time. I understand that if I revoke this right I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company. Unless otherwise revoked this authorization will expire on the following date: ___/___/___ . If I fail to specify an expiration date, this authorization date will expire in 90 days.

I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

This facility, it employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ **Date**: ___/___/___

Patient Signature (Or Parent / Legal Representative or Guardian)

Person Releasing Information (Print): _____

Relationship if not Patient _____