North Carolina Center for Reproductive Medicine, P.A.

400 Ashville Ave. Suite 200 Cary, NC 27518
Phone: 919-233-1311 ~ Fax: 919-233-1685

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print patient’s full name	Patient’s Date of Birth (Mo/Day/Yr)
Street address	Social Security Number
City, State, Zip Code	Home/Cell Phone Numbers
Patient Height	Patient Weight

At the request of the individual, I ____,
(patient’s name)

do hereby authorize ____ to release:
(name of facility)

____ Discharge Summary	____ Pathology Reports	____ Emergency Reports
____ History & Physical	____ Laboratory Reports	____ Other____________
____ Progress Notes	____ Radiology Reports	____________
____ Operative Notes	____ ECG/EEG/CARDIC CATH	____________

From time period of:_____________________ to _______________________________

Name of Facility:____

Address of Facility:____

Facility Phone #:__________________________ Facility Fax #:___________________

____ I do ____ I do NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), infections, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

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MAIL INFORMATION TO: NCCRM
400 Ashville Ave. Suite 200
Cary, NC 27518
Phone: 919-233-1311 Fax: 919-233-1685
Attention: Medical Records

____ Referral to Specialist ____ Insurance ____Workers' Comp

____ Legal Investigation ____ Disability Determination

____ Personal ____ Change of Doctor ____ Continuing Care

Please provide a current daytime phone number in care we need to contact you:

____

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

PLEASE NOTE: There may be a charge for records from your current physician's office

OFFICE USE:
MEDICAL INFORMATION RELEASED

Entire ____ Lab ____ EKG ____ HP _____
DS ____ Immune ____ Path ____ Other_________________
OP ____ X-Ray ____ Clinic ____ ROI Specialist______________________________
Number of Pages_____________
Date_______________________