NORTH CAROLINA CENTER FOR REPRODUCTIVE MEDICINE, P.A.
400 ASHVILLE AVENUE, SUITE 200, CARY, NC 27511
Phone (919)233-1680 Fax (919)233-1685

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

_____ _____
(Street address) social security number

_____ _____
(City, state, zip code) Phone

At the request of the individual, I _____, do hereby authorize **North Carolina Center for**
(Patient's name) **Reproductive Medicine, P.A.** to release:

_____ **PROGRESS NOTES**
_____ **OTHER DOCTORS NOTES**
_____ **OB/GYN NOTES**
_____ **HOSPITAL NOTES**

_____ **PATHOLOGY REPORTS** _____ **ALL RECORDS**
_____ **LABORATORY REPORTS** _____ **OTHER** _____
_____ **RADIOLOGY REPORTS** _____
_____ **ECG/EEG/CARDIC CATH**

____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 (Physician, hospital, agency, etc)

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:
_____ **REFERRAL TO SPECIALIST** _____ **INSURANCE** _____ **WORKERS COMP**
_____ **LEGAL INVESTIGATION** _____ **DISABILITY DETERMINATION** _____ **PERSONAL**

OTHER (SPECIFY) _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 3 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**

Reason for transferring: _____ _____

Please provide current telephone number in the event we need to contact you:

_____

NOTE: THERE WILL BE A MINIMUM CHARGE OF $10 FOR RECORD UP TO 10 PAGES WITH AN ADDITIONAL $.50 PER PAGE (FROM PAGE 11 TO 100) ADDITIONAL $.25 PER PAGE (FROM PAGE 101 & UP) + ACTUAL POSTAGE. ONCE INVOICE HAS BEEN PAID THE MEDICAL RECORDS WILL BE PRINT AND MAILED.