Primary Medical Care
270 Cornerstone Drive, Suite 105
Cary, North Carolina 27519
Phone 919-460-7676
Fax 919-460-4605

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Full Name : _____ Date of Birth: _____

Social Security Number: _____ Street Address: _____

Phone Number: _____ City, State, Zip: _____

Select one of the following:

Primary Medical Care to provide copies to □

Primary Medical Care to obtain copies from □

Information Release to

_____
Name (Physician, Hospital, Agency, etc.)

_____
Street Address

_____
City, State, Zip

_____

Select all that Apply:

A. Reason for Request □ Continued Care □ Insurance □ Attorney □ Personal □ Other

B. Information needed

□ All Records □ Labs □ Immunization/ Vaccination
□ Office Notes □ Pathology Reports □ History and Physical Examinations
□ Progress Notes □ Radiology Reports □ Operative Report/ Procedure Note
□ Other _____

□ Yes □ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I hereby authorize disclosure of the health information for the above named. 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 impact any information that was released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons, or facility receiving it, and would then no longer be protected by federal regulations.**Note: there will be a charge for records of .75 cents per page (from pages 1-25) .50 cents per page (from pages 26-100) and an additional .25 cents per page (from pages 100 and up) + actual postage of said records. CIOXX has been contracted to provide this service and will invoice you directly with a pre-bill invoice. Once the invoice is paid the medical records will be released.**

Patient Signature: _____ Date Signed: _____

Medical Information Released by CIOXX

□ ALL RECORDS □ PL/MEDS □ X-RAY
□ IMM □ LABS □ MAMMOGRAM CIOXX SPECIALIST: _____
□ PN □ PATHOLOGY □ EKG
□ OTHER: _____ NUMBER OF PAGES: _____ DATE: _____