Internal Medicine Associates of Raleigh, PA

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Records Release Authorization

Patient's Name: _____ Date of Birth: _____

Release From:		**Release To:**	
Name:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____
Phone:	_____	Phone:	_____
Fax:	_____	Fax:	_____

I authorize the following information to be sent to the above address:

____Copies of all medical records for the period: _____/_____/_____ to _____/_____/_____
____ Other (please specify): _____

Purpose of releasing this information: _____

____ Changing Insurance ____ Moving ____ Dissatisfaction with Doctor/Staff
____ Other (Please specify above)

***All medical records requests take 7 to 10 business days to process. There is a fee based on the number of pages, in accordance with North Carolina law.**

My signature below indicates that I understand what information will be released and the need for that information. I further understand that the information to be released may include information regarding drug and alcohol abuse or AIDS/HIV. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2. This consent will expire on _____, not more than 365 days from the date of signature.

I understand that I may revoke this authorization in writing at any time. This revocation will only be effective from the date it is received in this office and will not apply retroactively.

_____
Signature of legally responsible person

_____
Relationship

_____
Date