NORTH RALEIGH MEDICAL CENTER

11009 INGLESIDE PLACE,
SUITE 201, RALEIGH NC
27614
PHONE: 919-844-4344 FAX: 919-844-3244

Information Release Authorization

I,_____; hereby consent to the release and
Patient Name

disclosure of my personal health information to:

Physicians Name:_____

Address: _____

City: _____ **State:**_____**Zip:**_____

Phone:_____ **Fax:** _____

For the following purpose: □ Referral □ Physician Change □ My Primary Care MD

Other:_____

This release authorization includes my personal health information consisting of:

□ All Records □ Information for date of service _____□ Diagnosis _____

Other:_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within thirty (30) business days of North Raleigh Medical Center having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____

Patient Name

_____

Signature **Date of Birth** **Date**