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

Information Release Authorization

Physicians Name: _____

Address: _____

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

Phone: _____ **Fax:** _____

I hereby consent to the release and disclosure of my personal health information to:

NORTH RALEIGH MEDICAL CENTER
6729 FALLS OF NEUSE RD.
RALEIGH, NC 27615
919.844-4344 FAX: 919.844.3244

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**