Authorization for Release of Medical Records

to Dry Ridge Family Medicine

Patient Name ____

Address ____

City ____________________________ State ________ Zip ____________________

DOB _____ / _____ / _______ Phone # ________________________

I authorize the release of protected health information from:

Physician / Clinic ____

Address ____

Phone # ___________________________________ Fax #: ________________________________

Specific Description of the Information to be Released including the Dates of Service(s):

- ☐ Lab results & Radiology Reports - last 2 years
- ☐ Progress Notes - last 2 years
- ☐ Current Medication List
- ☐ Immunization Records

Other: ____

Release to: Dry Ridge Family Medicine
104 North Main Street
Weaverville, NC 28787
Phone: (828) 645-7974 **Fax:** (828) 645-9798

The information is requested for the following purpose(s):

- ☐ Facilitate coordination of care
- ☐ Other: ____

- I understand that if the person or entity that receives this information is not a health plan or health plan provider covered by federal privacy regulation, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Dry Ridge Family Medicine's Privacy Officer in writing. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Dry Ridge Family Medicine before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I understand this authorization will expire once the above is completed.

X _______________________________________ _____________________________
Signature of Patient or Personal Representative Date

_______________________________________ _____________________________
Printed Name of Personal Representative Relationship to Patient

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Witness (if needed or applicable)