

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:

Doctor / Clinic Name _____

Doctor/Clinic address _____

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

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):

Transfer of Medical 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

Witness (if needed or applicable)

Office use only Done by: _____ Date: _____
