

**AUTHORIZATION FOR
RELEASE OF MEDICAL
INFORMATION**



Date: _____

This authorization is for _____ to release information being
(Name of Previous Clinic)
requested of you, by you in order to comply with the terms of the Confidentiality of Medical Information Act.

Patient Name: _____

Birth Date: _____

Daytime Phone Number: _____

Social Security Number: _____

I Hereby Authorize: Clinic Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone number: _____ Fax number: _____

To Release Information To: **AA All American Family Healthcare, PLLC**

1750 Metromedical Drive

Fayetteville, NC 28304

Phone (910) 485-8831

Fax (910) 485-8832

medicalrecords@AAFFamilyHealth.com

This release limits disclosure to:

All Records Labs X-Ray Reports Immunizations Consult Notes

Other: _____

Information not to be released (if any): _____

A specific authorization is required to release information regarding the following:

HIV Information: Yes No Initials _____

Drug/Alcohol information: Yes No Initials _____

Mental Health Information: Yes No Initials _____

This information is required for: Change of Provider

Other (please specify): _____

This authorization will be valid until _____ (please indicate a date after which no information may be released. If no date is given, consent will be valid for 1 year)

I may revoke this authorization at any time, in writing, before the information has been released. I authorize the transmittal of this information via the selected transmittal format and release AA All American Family Healthcare, PLLC from liability for breach of confidentiality, misdirection, or failure to receive transmission.

FAX E-mail Electronic Media All three Initials _____

Patient Signature: _____

Parent, Guardian, or Authorized Representative: _____

Witness: _____