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@AAFamilyHealth.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 Breezewood 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: ____