

Atrium Obstetrics & Gynecology, P.A.
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
 Phone #919-781-9555 Fax #919-781-1070

 (Print patients full name)

 Birth date (Mo/Day/Yr)

 (Street Address)

 Social Security Number

 (City, state, zip code)

 Phone (Home)

At the request of the individual, I, _____ do here authorize:

Name of Company/Agency/Facility/Person

(_____) _____

phone number

Street Address **City, State, Zip Code**

(_____) _____

FAX number

To release to: **ATRIUM OBSTETRICS & GYNECOLOGY, P.A.**
2417 Atrium Drive, Suite 200
Raleigh, North Carolina 27607

___ DISCHARGE SUMMARY
 ___ HISTORY & PHYSICAL
 ___ PROGRESS NOTES
 ___ OPERATIVE NOTES

___ PATHOLOGY REPROTS
 ___ LABORATORY REPORTS
 ___ RADIOLOGY REPROTS
 ___ ECG/EEG/CARDIAC CATH

___ EMERGENCY REPORTS
 ___ OTHER: _____

From the time period of _____ to _____

___ I do ___ I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse

PURPOSE OF DISCLOSURE:

___ REFERRAL TO SPECIALIST ___ INSURANCE ___ WORKERS COMP ___ CHANGE OF DOCTOR
 ___ LEGAL INVESTIGATION ___ DISABILITY DETERMINATION ___ PERSONAL ___ CONTINUING CARE
 ___ OTHER (SPECIFY) _____

Please provide current daytime telephone number in the event we need to contact you _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class or persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

 Signature of individual or guardian or
 Personal Representative of patient's estate

 Date

PLEASE NOTE: WHEN REQUESTING TRANSFER OF MEDICAL RECORDS/INFORMATION FROM ONE PROVIDER TO ANOTHER, THERE MAY BE A FEE INCURED FOR COPYING SERVICES. YOU MAY WANT TO CHECK WITH YOUR PROVIDER REGARDING THIS.