Carolina Infectious Disease PA

Authorization for Release of Information

Patient Name: _____ **Date of Birth:** _____
(Last) (First) (MI)

Mailing address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Section 1

Information to be released from: Carolina Infectious Disease PA
Name of designated recipient

1774 Metromedical Drive | Fayetteville, NC 28304
Address | City, State, Zip Code

910-568-3903 | 910-568-3908
Phone Number | Fax Number

Section 2

Information to be sent to: _____
Name of designated recipient

_____
Address | City, State, Zip Code

_____
Phone Number | Fax Number

Section 3

Patient Authorization

Information to be released (check all that apply):

☐ All health care information in my medical record
☐ Health care information in my medical record specific to: _____
☐ Health care information in my medical record for the date(s): _____
☐ Other (e.g., X rays, labs, bills), specify date(s): _____

EXCLUDE the following information from the records released (check all that apply)

☐ HIV/AIDS ☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health ☐ Drug and/or alcohol use

Reason(s) for this request (check all that apply):

☐ Doctor ☐ Insurance ☐ Personal ☐ Attorney

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Section 4

- I understand that by signing this form, I am requesting that the health information specified in Section 3 be sent to the third party named in Section 2.
- I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in Section 1.
- If the organization, facility or professional named in Section 1 has already released health information based on my consent, my request to stop will not work for that health information.
- I understand that when the health information specified in Section 3 is sent to the third party named in Section 2, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date: _____ Or specific event: _____
MM/DD/YYYY

_____
Patient or legally authorized signature

_____
Relationship to patient

_____
Date signed