Chapel Hill Hormone Therapy

112 Perkins Drive, Suite 400 * Chapel Hill, NC 27514 * Phone (929) 960-2720 * Fax (919) 371-2334

Medical Information Release Form

Name:_____ Date of Birth: _____ Phone #: _____

I authorize Chapel Hill Hormone Therapy to:

❑ Receive OR ❑ Release Medical records and information from/to:

Name of provider or practice (Please include Key Contact at Practice):
_____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax number: _____

Reason for disclosure: ❑ Continuing care ❑ Personal ❑ Insurance ❑ Legal

Treatment dates to be disclosed: ❑ Past year ❑ All records

Information to be disclosed:

❑ Office notes ❑ Hospital records ❑ Lab results ❑ Diagnostic test results

❑ Consultations ❑ Other

Information NOT to be released: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Chapel Hill Hormone Therapy. I understand that my revocation is not effective to the extent that the persons or organizations which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature. I hereby authorize Chapel Hill Hormone Therapy to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment.
I hereby release Chapel Hill Hormone Therapy from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed. This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.

I agree to pay copy charges if applicable. There is a charge for printed records. The patient will be charged per North Carolina General Statues 90-411: $0.75/page for first 25 pages $0.50/page for pages 26-100 $0.25/page for pages over 100. Minimum fee of $10.00 permitted

_____

Patient's signature Date:

_____

Patient's representative signature and authority to sign Date:

_____

Witness: Date: