KAMM, McKENZIE OB/GYN
OBSTETRICS • GYNECOLOGY • INFERTILITY
3805 Computer Drive Raleigh, NC 27609
Phone 919-781-6200
Fax 919-783-1819

Authorization for Release of Information

PATIENT NAME: ____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____________ SS#: ______________ MEDICAL RECORD #: ____________
MO DAY YR

ADDRESS: ______________________ CITY: ____________ STATE: ______ ZIP: ________

DAY PHONE: ______________________ EVENING PHONE: ______________________

I hereby authorize ______________________________________ (Print name of provider)
to release information from my medical record as indicated below to:

NAME: ____

ADDRESS: ______________________ CITY: ____________ STATE: ______ ZIP: ________

PHONE: ______________________ FAX: ______________________

INFORMATION TO BE RELEASED:

DATES:

- ❑ History and physical exam ____________
- ❑ Progress notes ____________
- ❑ Lab reports ____________
- ❑ X-ray reports ____________
- ❑ Other: ____________ ____________
  ____________ ____________

I specifically authorize the release of information relating to:

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

X______________________________________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care
❑ Legal ❑ School ❑ Insurance ❑ Workers Compensation
❑ Other (please specify):
____

1. I understand that this authorization will expire on ____________ or (60) days after I have signed the form.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that by authorizing this release of information;

   a. My health care and payment for my health care will not be affected.
   b. I understand I may see and copy the information described on this form if I ask for it, and that if desired, I may get a copy of this form after I sign it.
   c. I have been informed that ______________________ (Print Name of Provider) ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

5. I understand that in compliance with ____________ (Print the State Whose Laws Govern the Provider) statute, I will pay a fee of $______________ (Print the Fee Charged).

______________________ ________ OR ______________________ ________
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

______________________ ________ ______________________
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED: ______________________ BY: ______________________

IDENTIFICATION TYPE PRESENTED: ______________________ FEE COLLECTED: $______

ID VERIFIED BY______________________