NC Elder Care

A Division of Horizon Internal Medicine, PLLC
1380 Eastchester Dr., Suite 103
High Point, NC 27265
Phone: (336) 521-9480
Fax: (336) 875-4705

CONSENT TO RELEASE MEDICAL RECORDS

From: _____

_____

_____

Please disclose the following:	To be used for the following purposes:
○ Medical Records	○ Per Patient Request
○ Treatment Records	○ Coordinated Care
○ Lab/Diagnostic Records	○ Transfer of Care
○ Other: _____	○ Other: _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during my care. These may or may not include substance abuse, other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc. unless herein excepted:

_____

By signing below, I hereby authorize and request that you release my medical records and/or other information concerning my healthcare and/or treatment to:

NC Elder Care
1380 Eastchester Dr. Suite 105, High Point, NC 27265
P. 336-521-9480 F. 336-875-4705

I also understand that I may revoke this authorization at any time by submitting a written notification to the address above. This notice will not apply to the actions taken prior to the date my revocation of authorization is received. I understand that this authorization expires twelve months from the authorization date, unless the need for disclosure is satisfactorily met within that twelve month period or if I provide written revocation of this authorization.

PATIENT AUTHORIZATION

PATIENT NAME: _____ DATE OF BIRTH: _____

_____ DATE:_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE