Carolina Primary Care and Internal Medicine
A division of Carolina Cape Fear Medical Group
3616 Cape Center Drive
Fayetteville, NC 28304
Phone: 910-868-6730 Fax: 910-829-964

Authorization to Release Information

Patient Name: _____ DOB: _____

_____ I hereby request a copy of my medical records as indicated below, be released to me.

_____ I elect to have these records mailed to me; records will be ready in twenty-one (21) business days.

_____ I elect to pick these records up in person; record will be ready in twenty-one (21) business days.

_____ I consent to and authorize: _____
Physician/Facility's Name Phone Number

_____
Address City State ZIP

to release my medical records to, as indicated below Carolina Primary Care and Internal Medicine

_____ I consent to and authorize Carolina Primary Care and Internal Medicine, to release my medical records as indicated below, to:

_____
Physician/Facility's Name Phone Number

_____
Address City State ZIP

Please select the specific type of information to be released includes:

_____ History & Physical

_____Operative / Procedure Report(s)

_____Consults/Office Notes

_____ Emergency Department Notes

_____Labs / X-rays / EKGs

_____ Consults, Progress Notes (Hospital)

_____Other (Specify) _____

I Do _____ I Do Not _____ authorize the release of portions of the record relating to substance abuse, psychological / psychiatric conditions and/or communicable disease, including immunodeficiency virus (HIV), if present.

I understand that I may revoke this consent at any time in writing except to the extent that the information has already been released pursuant to this consent and before I have revoked my consent. Otherwise, this consent shall continue to be valid only for as long as reasonably necessary to carry out the purposes enumerated above or unless it is with release to an Insurance company for payment for medical and/or hospitalization benefits, it will automatically expire one year after date signed, whichever is the earliest date. I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information It is possible that once disclosed the privacy of the information will no longer be protected under federal medical privacy law.

NOTE: Unless otherwise permitted by law, further release of this information is prohibited without prior written consent.

_____
Signature of Patient or Legal Representative Date

_____
State Relationship to Patient Phone Number

_____
Signature of Witness Date