NORTH BUNCOMBE FAMILY MEDICINE, PA

Sending Medical Record for Use and Disclosure

Patient's Name: _____

Patient's Date of Birth: _____ Last 4-digits of Patient's SS#: _____

Dates of Service Needed: □ Check for last 2 years or list specific date/range of dates: _____

I **authorize** North Buncombe Family Medicine, P.A. to send my medical record to:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

The description of information to be released (**circle** all that apply):

1. Office notes
2. Hospital notes
3. Lab/test results
4. Immunizations
5. Other:_____

The purpose of this authorization to release information is: _____

I understand that:

- This authorization includes, but not limited to, consent for the release of alcohol, drug, psychiatric and psychological information, cancer testing, cancer results and information relating to HIV testing, AIDS and AIDS-related syndromes.
- The information disclosed may no longer be protected by the federal privacy law and may be re-disclosed by the recipient.
- My decision to sign or not to sign this authorization will not affect the treatment provided to me by North Buncombe Family Medicine, P.A. ***I have the right to revoke this authorization at any time before use or disclosure of the information. Written notice is required to revoke this authorization and can be mailed or faxed to the attention of the Privacy Official of North Buncombe Family Medicine, P.A. All revocations are not effective until received by the Privacy Official.***
- This authorization will expire on _____. (This authorization will expire in one (1) year, unless date or event is indicated in blank provided.)
- A copy or fax of this authorization shall be as valid as this original.

North Buncombe Family Medicine, P.A.
201 Flat Creek Village Dr.
Weaverville, North Carolina 28787
Phone: 828-645-8525 Fax: 828-645-8935

_____

Signature of Patient/Guardian or Authorized Person (Documentation of authority required):

Date:

_____