CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

MediCopy Authorization for the Release of Medical Records

Where are the records coming from?

Facility/Doctor's Name: _____

Tell us about the patient.

Name:_____DOB:_____ SSN: _____-_____-_____

Email: _____

Address:_____

City:_____State:_____ Zip: _____

Phone#_____Fax#_____

Where are we sending the records?

Name: _____

Address:_____

City:_____State:_____Zip: _____

Phone#·_____Fax#: _____

What would you like released?

❒All Records ❒Lab/Pathology Results ❒Office/Clincal Notes ❒Radiology Reports

❒Operative Reports ❒ Immunization Records

Dates: _____to_____

Other: _____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded

❒Substance Abuse, if any ❒AIDS/HIV/STDs, if any ❒Psychological/ Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records ?

❒Personal Use ❒Litigation/Legal ❒Insurance ❒Continuation of Care ❒Transfer to New Physician

Delivery Method: How would you like the records sent?

❒Email ❒Fax ❒Postage (additional fee applies)

Patient's Signature

1 hereby authorize MediCopy and Its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notiftcation cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patients Signature:_____ Date: _____

Relationship to patient: _____

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