Raleigh OB-GYN Centre

4414 Lake Boone Trail, Suite 405
Raleigh, NC 27607
Telephone 919-876-8225
Fax Number 919-876-3371

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I authorize Raleigh OB/GYN Centre to obtain my medical records as indicated below.

_____ Medical Records from year_____to present.

or

_____ Records pertaining to _____

(medical problem or specific dates of treatment)

____I do ___I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and /or psychological assessment, and treatment for alcohol and/or drug abuse.

This information is to be obtained from: _____

(Name of Physician or Facility)

Required information

_____

(Street Address & Suite #)

Required information

_____

(City,State & Zip)

Required information

_____

(Phone # / Fax #)

Required information

PURPOSE OF DISCLOSER:

___Continuation of Care
___Change of Doctor
___Disability Determination
___Insurance
___Legal Investigation
___Personal
___Referral to Specialist
___Workers Comp
___Other_____

Patient Name: _____ Date of Birth: _____

(Please Print)

_____ SSN #: _____

(Current Address)

_____ Phone #_____

My signature below indicates that I understand what information will be released and the need for the information. I further understand that if my information is disclosed to someone who is not required to comply with federal privacy regulations, then such information may be re-disclosed and would no longer be protected. This consent will expire not more than 365 days from the date of signature. I understand that I may revoke the consent, verbally or in writing, at anytime, but that my revocation is only effective to the extent that action has not already been taken as a result of my signing this form.

Patient's Signature: _____ Date: _____

Parent/Guardian (If a minor) _____ Date: _____

Witness: _____Expiration date of consent_____