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Lillington Family Medical Center
PO Box 1687 Lillington, NC 27546
Phone (910) 893-2641 Fax (910) 893-3208

Authorization for Release of Medical Information

_____

(Patient's Name) (Birth Date) (Phone Number)

_____

(Address)

My Provider: [ ] John Briggs, MD [ ] Jessica M. Sloan, MD

I am: [ ] Requesting records FROM a facility [ ] Requesting records to be sent TO a facility

Facility Name and/or Doctor	**Facility Address**	**Phone**	**Fax**

_____ Emergency Reports _____ Lab Reports _____ Entire Record
_____ Discharge Summary _____ Radiology Reports _____ Other _____

Please FAX back to our office as soon as possible to Attention: Medical Records

Purpose of Disclosure:

_____ Referral to Specialist _____ Insurance _____ Workers Comp _____ Change of Doctor
_____ Legal Investigation _____ Disability Determination _____ Personal _____ Continuing Care

_____ I 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.

I hereby authorize disclosure of the health information for the above named patient. 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 will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished and may not condition its treatment of me on whether or not I sign the authorization.

_____

Signature of Patient or Legal Representative Date

_____

Witness Signature Date