Lillington Family Medical Center
7 East Duncan Street
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)

John L. Briggs, MD ☐ Jessica M. Sloan, MD ☐ William E. Hall, MD ☐ Monique I. Torres, PA-C ☐ Charles R. Donau, PA ☐

☐ Requesting records FROM a facility ☐ Requesting records to be sent TO a facility ☐ Patient pick up

☐ Change of Physician ☐ Continuing Care ☐ Other: _____

Facility Name and/or Doctor	**Facility Address**	**Phone**	**Fax**
1)			
2)			
3)			
4)			

☐ Most Recent ER Report _____ ☐ Radiology Reports ☐ Lab Reports

☐ Most Recent Discharge Summary _____ ☐ Other _____

☐ Entire Record (Last ____ years) _____

Please FAX back to our office within 72 hours to Attention: Medical Records

_____ 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