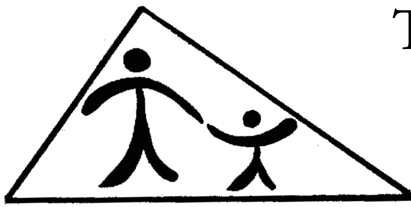

Triangle Family Care, P.A.

106-A Ridgeview Drive
Cary, NC 27511
Phone: 919-319-6363
Fax: 919-319-1331

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

Patient Name ______________________ *Birth Date: mm/dd/yyyy* ______________

Address ______________________ *Work Phone* ______________

City, State, Zip ______________________ *Home Phone* ______________

Medical Record Number ______________________ *Social Security Number* ______________

I, ______________________ do hereby authorize the release of the following protected health information for the date of: ____________ to ____________ .

*Please check the following: ❑ All records and all dates ❑ All records for dates above

❑ History & Physicals ❑ Progress Notes ❑ Laboratory Reports ❑ Pathology Reports
❑ Radiology Reports ❑ Discharge Summary ❑ ECG/EEG/EKG/Cardic Cath
❑ Emergency Reports ❑ OTHER ______________________

_______ I DO _______ I DO NOT authorize release of information related to AIDS (Acquired Immuno-deficiency Syndrome) or HIV (Human Immuno-deficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Release from: Name of Facility: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________ Fax: ______________

Released to: **Triangle Family Care, P.A.**
106-A Ridgeview Drive
Cary, NC 27511

Purpose of disclosure: ❑ Permanent transfer ❑ Referral to Specialist ❑ Legal Investigation
❑ Insurance ❑ Disability ❑ Worker's Comp. ❑ Personal Use
❑ Other: ______________________

____

Signature of Patient, Legal Guardian Or Personal Representative of Patient's Estate Date

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

04/06