

1540 Sunday Drive, Raleigh, NC 27607 | P. 919-782-3456 | F. 919-783-1441 (Adults)  
1520 Sunday Drive, Raleigh, NC 27607 | P. 919-782-3456 | F. 919-788-8986 (Pediatrics)  
10880 Durant Road, Raleigh, NC, 27614 | P. 919-850-0335 | F. 919-855-0953  
3901 North Roxboro Road, St. 501, Durham, NC, 27704 | P. 919-719-8834 | F. 919-582-0528

## Medical Records Release

### Patient Information:

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ SRS # \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Information to be released from: \_\_\_\_\_

Information to be sent to: \_\_\_\_\_

### Information to be released:

- The most recent pertinent information (chart notes, labs, radiology reports, medication lists and special testing.)  
 Specific health information: \_\_\_\_\_  
 **I Do**  Do Not authorize release/request for information regarding drugs, alcohol, HIV or mental health.

The information below is being disclosed for the following purpose:

\_\_\_\_\_

This authorization shall be in effect until the information has been forwarded/obtained as requested.

### Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the medical record department at RNA.

Signature of Patient or Authorized Personal Representative \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_