Impact Primary & Urgent Care
315 Franklin Plaza, Louisburg, NC 27549
Phone (919)-496-4976 Fax (919)-496-4978

Authorization to Release/Request for an individual's Health Information/Treatment Records

Last Name:____________________________ **First:**____________________________ **Middle:**_____________

Other Names Used:____ **D.O.B.**_________________________

Address:____ **City:**_____________________ **State:**______

Home ph:_(______)_____________ **Cell ph:**_(_____)____________ **Work ph:**_(______)______________

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I hereby request access to the protected health information in my health record and/or my treatment record from (date)_______________________ to (date)___________________ maintained by the provider named below to the recipient below.

☐ Entire Medical Record ☐ Insurance ☐ Progress Notes ☐ Billing Information ☐ Consultation ☐ Test Results
☐ Radiology Report ☐ Medication Records ☐ Discharge Summary ☐ Nurses Notes ☐ Radiology Images
☐ History & Physical ☐ Physician Dictation ☐ Surgery Report ☐ Laboratory Report ☐ Other(Specify)____________

How to Deliver Health Information: ☐ I will pick up records ☐ Fax my records to the individual noted below
☐Mail copies of my records to the individual noted below ☐ Provide my records in electronic form:__________________________

RECORDS FROM:		RECORDS TO:
Name:	**Impact Primary & Urgent Care**	**Name:**
Address:	**315 Franklin Plaza**	**Address:**
City/State/Zip:	**Louisburg, NC 27549**	**City/State/Zip**
Phone:	**919-496-4976**	**Phone:**
Fax:	**919-496-4978**	**Fax:**

Reason to Disclose Health Imformation: ☐ My (Patient) Request ☐ Treatment ☐ Disability
☐ Other (Describe): ☐ Worker's Compensation ☐ Insurance ☐Legal

IMPORTANT NOTICE: This is a full release, including drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:____

I understand:

1. I can cancel this permission at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel the sharing of information already given as a result of this permission.
2. I do not have to sign this form. Refusal will not change my ability to get treatment, payment for treatement, or benefits.
3. By law, Internal Medicine of Wakefield cannot use or share my health information withour permission, except by ways listed in Internal Medicine of Wakfield's Notice of Privacy Practices.
4. I have read, understand, and upon my request, been given a copy of this form.
5. This is not for use for Marketing or Research.

NOTICE: A fee may be charged to make copies of the requested medical record.

My permission ends 12 months after the date I signed, unless a date or event is written here:_____________

____ ______ ____

Patient or Patient Representative Signature **Date** **Witness Signature** **Date**

Legal Authority to Sign for patient: ☐Healthcare agent ☐Guardian ☐Attorney in Fact ☐Parent ☐Next of Kin ☐Administrator/Executor

If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the admistrator/executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.

Patient is: ☐Minor ☐Disabled ☐Deceased ☐Incompetent ☐Incapacitated