



Clayton Medical Associates, P.A.
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DR. JOAN N. MEEHAN
 BOARD CERTIFIED
 FAMILY PRACTICE

DEBORAH B. ROBERSON, FNP-C
 FAMILY NURSE PRACTITIONER

ALISON L. ELDRIDGE, ANP-C
 ADULT NURSE PRACTITIONER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

 (Print patients full name) Birth date (Mo./Day/Yr.) _____

 (Street Address) Social Security Number _____

 (City, state, zip code) Home phone number _____

I, _____, do hereby authorize _____ to release:

- (Patient's name)
- | | | |
|---|--|--|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> ED reports |
| <input type="checkbox"/> H&P, Discharge notes | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Other |
| <input type="checkbox"/> OP Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> EKG/Cardiac Reports |

From the time period of _____ to _____

I do I do NOT authorize release information related to AIDS or HIV infection, psychiatric care and/or psychological assessment, and treatment for drug and/or alcohol abuse.

INFORMATION RELEASE TO:

 Name of Company/Agency/Facility/Person

 Street address

 City, State, Zip

PURPOSE OF DISCLOSURE:

- | | | | |
|---|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance Application | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Change of MD |
| <input type="checkbox"/> Attorney Request | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Personal | <input type="checkbox"/> Other _____ |

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for _____ from the date of signature. I understand that I may cancel this request with written notification but that it 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 entity receiving it and would no longer be protected by federal regulations. I understand that the medical provider to whom this information is furnished may not condition its treatment of me on whether or not I sign this authorization.

Signature of Patient (or responsible party)

Date