

**ROCKY MOUNT FAMILY MEDICAL CENTER, PA**  
**804 English Road – Rocky Mount, NC 27804**  
**Phone 252-443-3133 Fax 252-443-6726**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
(**PRINT** patients full name)  
\_\_\_\_\_  
(Street address)  
\_\_\_\_\_  
(City, state, zip code)

\_\_\_\_\_  
Birth date (Mo/Day/Yr)  
\_\_\_\_\_  
Social security number  
\_\_\_\_\_  
Phone (Home)

At the request of the individual, I \_\_\_\_\_, do hereby authorize \_\_\_\_\_ to release:  
(Patients Name) (Name of Facility)

DATES OF _____	
_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS
_____ EMERGENCY REPORTS	_____ HISTORY & PHYSICAL
_____ LABORATORY REPORTS	_____ PROGRESS NOTES
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIC CATH
_____ RADIOLOGY REPORTS	_____ OTHER _____

\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_ I do \_\_\_\_\_ I do NOT 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.

**INFORMATION RELEASE TO:**

\_\_\_\_\_  
Name of Company/Agency/Facility/Person  
\_\_\_\_\_  
Street address  
\_\_\_\_\_  
City, state, zip

**PURPOSE OF DISCLOSURE:**

\_\_\_\_\_ REFERRAL TO SPECIALIST \_\_\_\_\_ INSURANCE \_\_\_\_\_ WORKERS COMP \_\_\_\_\_ CHANGE OF DOCTOR  
\_\_\_\_\_ LEGAL INVESTIGATION \_\_\_\_\_ DISABILITY DETERMINATION \_\_\_\_\_ PERSONAL \_\_\_\_\_ CONTINUING CARE  
OTHER (SPECIFY) \_\_\_\_\_

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 it will not effect 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 may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
**Signature of individual or guardian or  
Personal Representative of patient's estate**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**WITNESS** *Must be witnessed by an FMC employee  
or notarized if not signed in office.*

\_\_\_\_\_  
**Date**

Confidential patient information may be accessed by employees of Smart Corporation for purposes of photocopying the information in response to properly authorized request for copies of medical records. The fee for obtaining a copy of your records will be as follows: \$.75 per page (1-25), \$.50 per page (26-39 w/ cap of \$25.25), \$.15 per page for 40+. Smart Corporation will invoice you directly. Any questions may be directed to 770-754-6000. Employees of Smart Corporation are bound by the same confidentiality requirements, as are employees of this facility.