FAMILY MEDICAL CENTER
Rocky Mount

804 English Rd., Suite 100 • Rocky Mount, NC 27804
Phone 252-443-3133 • Fax 252-443-6726

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____

Medical Record Number: _____ Birth Date: _____

Address: _____

City/State/Zip: _____

Phone #: _____ DL #: _____

Email: _____

Rocky Mount Family Medical Center may release this information to: ❑ Check if same as above

Release ❑ To ❑ From _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax: _____

This disclosure can be used for the following: ❑ Personal Use ❑ Legal ❑ Insurance

❑ Change Doctor ❑ Disability ❑ Cont. Care ❑ Workers' Comp Other: _____

Check ONLY one of the following three options to identify the health information to be released.

❑ **Option 1:** Last 4 office visits, labs and DI. - Free of Charge (Applies to RMFMC records only)

❑ **Option 2:** Last 2 years of RMFMC records (Applicable charges may apply)

❑ **Option 3:** Records as specified. You must complete Step 1 and Step 2 below. (Applicable charges may apply)

Step 1. Enter date range or date(s) of the records to be released: _____

Step 2. Select types of records to be released:

❑ Office Visit ❑ Progress Note ❑ Immunization ❑ Lab Results ❑ Diagnostic Images

❑ Other: _____

NOTE: Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical records.

Check the boxes below if you want this release to include the following information, otherwise this information will be excluded.

❑ Mental Health Treatment Records ❑ Addiction Medicine Treatment Records ❑ HIV Test Results

Media Type: ❑ Fax ❑ Paper ❑ Other: _____ **Delivery Preference:** ❑ US Mail ❑ Pickup ❑ Other: _____

DURATION: I hereby authorize disclosure of the health information for the above patient named. 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 my 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.
REDISCLOSURE: Once this information is released, it may not be protected under federal privacy law (HIPPA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Confidential patient information may be accessed by employess of ScanSTAT 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: Paper copies $.45 per page (1-10 pages), $.22 per page (11+ pages), $.25 per for Electronic duplication of records. $.45 pdf image (1-10 images), $.12 per image (11+ images). Charges for the actual cost of postage will also be added to the invoice. ScanSTAT will invoice you directly. All invoices will be billed by ScanSTAT. Upon receipt of your invoice, simply include the bottom portion of your invoice along with your check for the balance due. In addition, your invoice will include a phone number should you choose to pay by credit card or you may go to www.scanSTAT.com to pay your invoice. Any questions may be directed to 770-569-2445. Employees of ScanSTAT are bound by the same confidentially requirements, as are employees of this facility.

Date _____ Signature _____ If personal representative, print name/relationship _____

Date _____ Witness (must be witnessed by RMFMC employee or notarized if not signed in office) _____