Drivers License# ______________

FAMILY MEDICAL CENTER OF ROCKY MOUNT

804 English Road, Suite 100 – Rocky Mount, NC 27804

Phone: 252-443-3133 Fax: 252-443-6726

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________________ (***PRINT*** patients full name)

______________________________ Birth date (Mo/Day/Yr)

______________________________________ (Street address)

______________________________ Social security number

______________________________________ (City, state, zip code)

______________________________ Phone (Home)

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

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

The facility releasing your medical information may charge you a fee for their services.

_____ 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 FMC employee or notarized if not signed in office.***) **Date**

Confidential patient information may be accessed by employees 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: $.75 per page (1-25 pages), $.50 per page (26-100 pages), $.25 per page for 100+ pages. 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 confidentiality requirements, as are employees of this facility.