GENERATIONS
FAMILY PRACTICE

110 Preston Executive Drive
Suite 100
Cary, NC 27513
P: 919.852.3999 F: 919.378.9114

RELEASE OF MEDICAL RECORD INFORMATION
Release to Generations Family Practice
This authorization expires ninety (90) days from date of signature

PATIENT NAME _____ DOB _____

Reason for Request: _____ Medical (continuing care) _____ Personal

_____ Medical (transferring care) _____ Other

I hereby authorize the following clinician/facility and staff to disclose my protected health information to Generations Family Practice:

1. The following person, or facility may release my protected health information.

Name _____

Address _____

Phone (____) _____ Fax (____) _____

2. Complete Record _____ Partial Record _____ through _____

ATTENTION: Unless you sign here, no information may be released regarding **alcohol or substance abuse, HIV/AIDS, or mental health. YES, disclose this information** _____
Signature

_____ **No, DO NOT disclose this information**

3. I understand that my protected health information may be re-disclosed by the person/facility receiving it, and would at that time no longer be protected by federal privacy regulations.

4. This authorization expires ninety (90) days from date of signature or **sooner**, (1) if at any time I should revoke it, or (2) upon the occurrence of the following expiration event for which this disclosure was authorized.

5. Please send records to: **Generations Family Practice, 110 Preston Executive Drive, Suite 100, Cary, NC 27513** or fax to **(919) 378-9114.**

_____ _____
Signature of Patient/Guardian or Representative Date

Description of representative's authority to act for patient: _____