



**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: \_\_\_\_\_