Family Centered Healthcare, PA
400 Millstone Drive, Suite 100
PO Box 1119
Hillsborough, NC 27278
Phone: 919) 245-3247, FAX: (919) 732-3864

ATTENTION: RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize: (name of medical facility)

_____

_____

_____

_____

To disclose to:
Family Centered Healthcare
400 Millstone Drive, Suite 100
PO Box 1119
Hillsborough, NC 27278
Phone:(919) 245-3247, FAX: (919) 732-3864

The protected health information of:

Patient Name_____ Date of Birth ____/____/_____

Address_____

City_____ State_____ Zip Code_____

Telephone_____ Social Security Number (optional)_____

Treatment dates_____ Responsible Party: _____

Information to be disclosed:
☐ Progress Notes, ☐ Medication Lists/Allergies, ☐ Problem List, ☐ Laboratory values,
☐ Tests/Studies: _____ ☐ Other: _____

The purpose or use of this disclosure is (CHECK ONES THAT APPLY):
☐ Personal ☐ Attorney/legal ☐ Continue Patient Care ☐ Insurance ☐ Social Service/Disability
☐ Other: _____

I understand that the data to be released may include information protected by law. I may revoke the authorization at any time, and such action will not apply to information that has already been released in response to this Authorization. I must make this request in writing to the forementioned parties.

I have read and understand the information in this Authorization form.

Patient's/ Responsible Party's Name: _____ Date: _____

Patient's /Responsible Party's Signature: _____