RELEASE OF INFORMATION
AUTHORIZATION / REQUISITION FORM (Circle One)

Section A: *This section to be completed by the patient.*

Patient Name:		**Medical Record #:**	
Address:		**Social Security #**	
		Date of Birth:	

RELEASING Facility	**Facility Name:**	
	Address:	
	City/State/Zip:	
	Phone #:	
REQUESTING Facility or Individual	**Requestor Name:**	BEACHCARE URGENT AND FAMILY MEDICAL CENTER, PLLC
	Address:	5059 HWY 70 West
	City/State/Zip:	MOREHEAD CITY, NC 28557
	Phone #:	252-808-3696 Fax 252-808-2022
Date(s) of Service:		

List specific information to be released	___ **Anesthesia**	___Disharge Summary	___Imaging Reports	___Orders	___ All Records
	___ **Billing Records**	___EKGs	___ Laboratory	___Outpatient	___ Other
	___ UB92	___Emergency	___Medication	___Pathology	_____
	___ Itemized Bills	___Face sheet	___Nursing	___Progress Notes	_____
	___ Consultation	___History & Physical	___Surgery/Procedure	___Accounting of Disc	_____

Section B: *This section to be used for providers own disclosure purposes:*

Purpose of Disclosure:

Will Physician receive financial or "in-kind" compensation for the use/disclosure of information described above?	☐ Yes	☒ No

Section C: *Must be completed by he patient for all authorizations.*

The patient or the patient's representative must read and complete information in this section:

1. I understand that the person's hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on _____/_____/_____.
3. I understand that I may revoke this authorization at any time by notifying the Physician's office in writing, except to the extent the Physician's office has already taken action in reliance on the previous authorization.
4. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
5. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
6. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this aurhotization will not affect my treatment.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that this authorization also applies to records about me containing information about HIV, AIDS, venereal disease, or mental disorders. In accordance with federal regulation 42 CFR part 2: I also understand that any and all alcohol and/or drug abuse treatment information cannot be released without my specific authorization, except in special circumstances. Therapist notes related to mental disorders will also require a specific authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations.

(Signature of Patient or Patient's representative) (Date)

(If patient representative, please print name above)

FOR OFFICE USE ONLY:		
Verified:	**Yes**	**No**
By:		
License # N/A		
SS# N/A		
Signature	Yes	No