AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Hampstead Family Medicine
144 Merchants Circle
Hampstead, NC 28443
Phone:910-803-0340
Fax: 910-803-0342

Burgaw Medical Center
311 South McNeil St.
Burgaw, NC 28425
Phone: 910-259-3377
Fax: 910-259-3013

Patient's Full Name _____________________________ Birth Date__________ Sex: Male / Female

____

Street Address Social Security Number

____

City, State, Zip Code Phone Number

I ____________________, hereby authorize the release of my medical information

from ____

Facility Name, City and State

Phone: ____________________________ Fax: ____________________________

RELEASE RECORDS TO: Hampstead Family Medicine/Burgaw Medical Center

Specific Information to be disclosed:
__DISCHARGE SUMMARY __HISTORY & PHYSICAL __PROGRESS NOTES
__OPERATIVE NOTES __PATHOLOGY REPORTS __EMERGENCY REPORTS
__LABORATORY REPORTS __RADIOLOGY REPORTS__ECG/EEG/CARIAC CATH
__OTHER _________________________

PURPOSE OF DISCLOSURE: __CONTINUATION OF CARE __TRANSFER OF CARE

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 affect any information released prior to the 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 to be furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Individual/Guardian: ______________________________ Date: ________________

Witness: __________________________________ Title: __________________