Raleigh Infectious Diseases Associates, P.A.
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CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Name_____
Patient's Date of Birth_____ **Social Security #**_____

I. CHOOSE ONE (*Place an "X" to indicate your choice*):

- ☐ Send records to whom: ☐ Dr. ☐ Mr. ☐ Ms._____
  {Address}_____
- ☐ Patient (self) will pick up a copy of the medical records.
- ☐ Information available upon request _____
- ☐ Patient will allow ☐ Mr. ☐ Ms. _____
  to pick up a copy of records. (Identification Required)
- ☐ Fax records to Attention: ☐ Dr. ☐ Mr. ☐ Ms. _____
  Fax number (_____) _____-_____
- ☐ Electronic Copy via Secure CD – (Charge of $25.00)

II. Information to be Disclosed: ☐ Raleigh Infectious Diseases Records ☐ All Medical Records
FROM {DATE} ____/____/_____ TO {DATE} ____/____/_____, **including:**

- ☐ History/Physical
- ☐ Discharge Summary
- ☐ Consultation and Office Notes
- ☐ Other _____
- ☐ Labs, including culture reports
- ☐ Radiology Reports

III. This information for which I am authorizing disclosure will be used for the following purpose. (***Place an "X" to indicate your choice***):

- ☐ my personal records
- ☐ sharing with other health care providers as needed
- ☐ other (please describe): _____

IV. CONSENT AND AUTHORIZATION

I hereby consent and authorize _____ to release copies of my medical records including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. I agree to indemnify and release the above provider from any liability resulting from this release. I understand that medical records related to HIV testing, AIDS, AIDS-related syndrome, sexually transmitted diseases, alcohol/drug/substance abuse or mental health diseases will be included in this correspondence.

V. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, except to the extent that Raleigh Infectious Diseases Associates has already used or disclosed information in reliance on this authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 360 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient until this authorization is revoked or expires, and no longer protected by the HIPAA Privacy Regulations.

_____ _____ _____
Patient Signature Date Witness
Expiration Date _____