PIEDMONT MEDICAL ASSOCIATES, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: ( ) From: ( )

_____

(Name of Company/Agency/Facility/Person)

_____

(Street Address or Fax Number)

_____

(City, State, Zip Code)

PLEASE RELEASE MEDICAL RECORDS

To: ( ) From: ( )

Piedmont Medical Associates, P.A.
3400 Executive Drive, Suite 205
Raleigh, NC 27609
(919) 878-0900
(919) 872-2456 FAX

THE FOLLOWING INFO IS REQUIRED FOR THE DATES OF :_____

___DISCHARGE SUMMARY	___PATHOLOGY REPORTS	___EMERGENCY REPORTS
___HISTORY & PHYSICAL	___LABORATORY REPORTS	___ALL RECORDS
___PROGRESS NOTES	___RADIOLOGY REPORTS	___OTHER _____
___OPERATIVE NOTES	___ECG/EEG/CARDIAC CATH	_____
		_____

THE FOLLOWING ARE OPTIONAL/IF APPLICABLE

___ I DO ___ I DO NOT authorize release of information related to AIDS (Acquired Immunodeficieny Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and or psychological assessment, and treatment for alcohol and drug abuse.

___ I DO NOT authorize the release of _____

PURPOSE OF DISCLOSURE

___SPECIALIST REFERRAL	___INSURANCE	___WORKER'S COMP	___CHANGE OF DOCTOR
___LEGAL INVESTIGATION	___DISABILITY	___PERSONAL	___CONTINUING CARE

___OTHER (Please specify)_____

PATIENT INFORMATION

_____ _____

(Name of Patient) (Date of Birth)

_____ _____

(Street Address) (Social Security Number)

_____ _____

(City, State, Zip Code) (Primary Contact Number)

I hereby authorize disclosure of the health information for the above named patient. This authorization will remain 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 effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or facility receiving it. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization.

_____ _____

(Patient's signature, individual guardian or legal representative of patient's estate) (Date)

_____ _____

(Witness from Piedmont Medical Assoc. - may be required) (Date)

NOTE: There may be a charge billed to the patient for personal, insurance, change of doctor, disability and other non-medically necessary requests for medical records. Healthport has been contracted to provide this service and will invoice you directly. You may contact them at 800.822.1665.