Drossman Gastroenterology

55 Vilcom Center, Suite 110, Chapel Hill, NC 27514 Phone: 919-929-7990 Fax: 919-929-7991

Medical Information Release Form

Patient:	Date of Birth:	Patient Phone Number:

I, _____, the patient/guardian/healthcare power of attorney,

authorize **Drossman Gastroenterology to** **(circle one)**

___ **receive** medical and other information from:

___ **release** medical and other information to:

Individual Name or Practice (required):

_____

Phone (required): _____Fax: _____

Specify Email or Street Address*: _____

City (required): _____ State: _____ **Zip Code**: _____

***There is a charge for printed records**. *If records are being requested to be sent to a lawyer, insurance or workers compensation company, please have them contact us with a written request; otherwise the patient will be charged per North Carolina General Statues 90-411: printed Records Medical Record charges inclusive of searching, handling, copying, and mailing costs are: $.75/page for first 25 pages $.50/page for pages 26-100 $.25/page for pages over 100 Minimum fee of $10.00 permitted*

TREATMENT DATES TO BE DISCLOSED: ☐Entire ☐Year to Date ☐Other_____

PURPOSE OF THE DISCLOSURE: ☐Insurance ☐Legal ☐Continuing Care ☐Personal ☐Other (specify)

_____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

☐History and Physicals ☐Progress Notes ☐Hospital ☐Correspondence

☐Labs and X-rays ☐Insurance ☐Miscellaneous ☐All

SPECIFIC INFORMATION TO **NOT** BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that one the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Drossman Gastroenterology. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize Drossman Gastroenterology to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release Drossman Gastroenterology from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.

_____ _____

PATIENT'S SIGNATURE **DATE**

_____ _____

PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN **DATE**

_____ _____

WITNESS **DATE**