

FamilyCare

3164 US Hwy 70 Black Mountain, NC 28711
Phone: 828-669-4505 Fax: 828-669-5112

GENERAL MEDICAL RELEASE/ AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ SSN: _____

I authorize **Family Care of Black Mountain/Old Fort** to disclose the following information

- ☐ Complete Medical Records**
- ☐ Laboratory/Pathology Reports only
- ☐ X-ray/Radiology Reports only
- ☐ Progress Notes**
- ☐ Pharmacy/Prescription Records
- ☐ Other (please specify) _____

**NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information

These records are for services provided on the following date(s): _____

Please send above requested records to:

This information may be used/disclosed for each of the following purposes:

- ☐ For my health care
- ☐ For payment/insurance
- ☐ For Employment Purposes
- ☐ Transfer of Care
- ☐ Other: _____

**This authorization will be valid for 180 days or until notification from the patient (whichever is sooner). This authorization may be revoked at any time by notifying the privacy officer in writing. I do hereby consent and authorize release of copies of my medical records designated above. Any release of information made prior to my revocation shall not constitute a breach of my rights to confidentiality.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

Date