

Medical Records Release

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

SS #: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below. I hereby authorize \_\_\_\_\_ to release the following information:

\_\_\_\_\_ Entire Chart of Medical Records

\_\_\_\_\_ Specific Records Listed Below:

I do \_\_\_ I do not \_\_\_ authorize the release of information related to AIDS or HIV infection, sexually transmitted diseases, psychiatric care, and or psychological assessment, and treatment for alcohol.

Please release records to Dr. Mary Cox, D.O. at

80 Aviemore Court  
Suite B  
Pinehurst, NC 28374

Phone: 910-215-0892  
Fax: 910-215-0896  
Urgent Fax: 910-215-0890

Authorized Private Health Information will be used and disclosed for the following purposes. I have received a copy of Dr. Mary Cox—D.O. Notice of Privacy Practices. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment payment, enrollment in a health plan or eligibility or benefits. I also understand my signature will be required to prior to my request being completed.

Dr. Mary Cox—D.O. may use or disclose such protected health information only until expiration date of expiration event relating to the individual or purpose of the use or disclosure.

At all times, I retain the right to revoke this authorization. Such revocation may be submitted in writing to Dr. Mary Cox—D.O. at 80 Aviemore Court, Suite B, Pinehurst, NC 28374. I understand that information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient of such information, and at that point, the information may no longer be protected under the federal or state confidentiality rules.

This authorization will automatically expire 6 months from the date signed.

I understand that I maybe required to pay a fee for copying these medical records

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_