TRIANGLE FAMILY MEDICINE

Authorization for Release of Medical Information

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Patient Information

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

OR

☐ I authorize Triangle Family Medicine **to release information to:**	☐ I authorize Triangle Family Medicine **to obtain information from:**
Provider Name: _____	Provider Name: _____
Office Name: _____	Office Name: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____

Purpose For This Request (check one) [ ] Transfer of care [ ] Continuity of care [ ] Other

Type of Records Requested (check one)

[ ] Immunization history [ ] Laboratory test results [ ] Office visit notes _____
Dates of Treatment

[ ] All medical records related to a specific illness or injury _____
Specify illness/injury Dates of Treatment

[ ] Complete Medical Records

Authorization Valid For: (check one)

[ ] This request only

[ ] One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

[ ] This request **and** for medical records of any **future** treatment of the type described above until _____ (insert date)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information above could be redisclosed.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient *(if requester is not the patient)*: _____