CONE HEALTH®

Primary Care

MEDCENTER KERNERSVILLE

1635 NC 66 South
Suite 210
Kernersville, NC 27284
Phone: 336-992-1770 Fax: 336-992-4899

Medical Records Release Form
(from another practice to ours)

Patient Name____ Date of Birth_________________
Telephone_____________________________ Social Security # ______________________________
Address____

I hereby authorize the use or disclosure of my individual identifiable health information as described below. This includes information pertinent to mental health, drug/alcohol abuse and HIV/AIDS diagnosis. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations.

I authorize Cone Health Primary Care at MedCenter Kernersville to request progress notes, labs, xrays, procedure notes and immunizations from the last 1 year.

Please indicate if you would like your records once we receive them. Yes / No

Please request records from:

Dr. ____ Phone:________________________

Address:____ Fax:__________________________

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless revoked earlier, this authorization will expire on____/____/____.
   Initials:___________
b. I understand that I may revoke this authorization at any time by notifying Cone Health in writing, but if I do, it won't have any effect on any actions Cone Health took before it received the revocation.
   Initials:___________
c. I understand that Cone Health cannot make me sign this authorization as a condition to receive treatment from Hospital except:
   1. When Cone Health provides me with research-related treatment, or
   2. When Cone Health provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

   Initials:___________
d. **I understand there may be a charge for reproduction of medical records/films/tapes.**
   Initials:___________

Hospital, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

____ _______________________________
Signature of Patient Date

____ _______________________________
Signature of Parent/Guardian/Auth. Repres Date

____ _______________________________
Witness Signature Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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