focusMD

Authorization for Release of Medical Information

Patients Name _____ DOB: _____ SSN:_____

Address: _____City _____State ____ Zip Code_____

Phone Number_____ Date of Request:_____

Focus-MD Raleigh
4822 Six Forks Rd, Suite 102
Raleigh, NC 27609
Phone: 919-336-4244 Fax: 877-710-0710

☐ I authorize Focus-MD **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

☐ I authorize Focus-MD **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST (check one) ☐ Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Attorney/Legal ☐ Continued Care (Consult/Referral)

TYPE OF RECORDS REQUESTED (check one)

☐ Complete medical record

☐ Summary of records (Includes: Last well check, detailed summary of all visits, growth chart, allergies, and medication list)

☐ Office Notes

☐ Specific Treatment (select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Testing Results ☐ Medication List ☐ Surveys/Assessments ☐ Office Notes

AUTHORIZATION VALID FOR: (Check one):

☐This request only.

☐One year from the date of this authorization. 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 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 stated above could be re-disclosed.

Signature of Patient or Representative_____ Date: _____

Relationship to Patient (If requester is not the patient) _____

Witness Signature: _____ Date: _____