**High Rock Internal Medicine**
**Authorization for Release of Medical Information**

Patient name: _____ Date of Birth: _____
Address:_____ Telephone: _____
_____

I authorize the release of medical information as indicated below:

**From: _____**
_____
_____

**To: High Rock Internal Medicine**
**104 W. Medical Park Drive**
**Lexington, NC 27292**
**Phone: 336-224-0931**
**Fax: 336-224-0932**

**What to release: Please choose the records you would like released:**

[ ] All medical records [ ] Radiology reports [ ] X-ray CD
[ ] Last 18 months [ ] Laboratory reports
[ ] Other_____

**Note: The records listed below have special protection by laws. I authorize the release of information pertaining to:**

The diagnosis or treatment of AIDS, including results of HIV tests [ ] Yes [ ] No/ NA
The diagnosis or treatment of drug and/or alcohol abuse [ ] Yes [ ] No/ NA
The treatment and/or consultation for mental health or psychiatric disorders [ ] Yes [ ] No/ NA

**Purpose of the release: Please indicate the reason for this release**

[ ] Transfer of care [ ] For another doctor/specialist [ ] Personal Use [ ] Employment
[ ] Legal purposes [ ] To obtain disability [ ] School

**This authorization is only valid for one time use and for the purpose stated.**

*I understand this authorization can be revoked at any time according to the privacy practices of High Rock Internal Medicine. This request must be made in writing and sent to the same place as the original request. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.
*Once these records are released, the information is not protected by High Rock Internal Medicine and may potentially be re-disclosed by the party who received these records. High Rock Internal Medicine, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.
*I have read and understand this information. I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

****Our office uses an outside company called HealthPort to process all medical records requests. They will copy your medical records and bill you for this service, if applicable, based on regulated rates.**

_____ _____
Signature of the patient Date

_____ _____
Signature of legal representative and relationship to patient Date

_____ _____
Signature of witness Date