<u>High Rock Internal Medicine</u> <u>Authorization for Release of Medical Information</u>

Patient name:Address:			Date of Birth:	Telephone:	
			Telephone:		
I autho	rize the release of medica	al information as indicated below:			
From:	High Rock Internal Me	edicine To:			
	104 W. Medical Park D	rive			
	Lexington, NC 27292 Phone: 336-224-0931				
	Fax: 336-224-0932				
What t	o release: Please choose	the records you would like releas	od:		
	nedical records	[] Radiology reports	[] X-ray CD		
[] Last	18 months	[] Laboratory reports			
		nave special protection by laws. I a			
The diagnosis or treatment of AIDS, including results of HIV tests			[]Yes []No/NA		
The diagnosis or treatment of drug and/or a The treatment and/or consultation for ment		<u> </u>	[] Yes		
disorde		on for mentarhealth or psychiatric	[] TES [] NO/ N	•	
-		ndicate the reason for this release			
	sfer of care	[]		[] Employment	
[] Lega	ll purposes	[] To obtain disability	[] School		
This au	thorization is only valid fo	or one time use and for the purpo	se stated.		
*I unde	rstand this authorization	can be revoked at any time accord	ing to the privacy practices of Hig	th Rock Internal Medicine. This	
		and sent to the same place as the	original request. Treatment, pay	ment, enrollment in any health	
•	not conditioned on signing				
		d, the information is not protected	, -		
		ceived these records. High Rock Int responsibility or liability for release		-	
authori	_	responsibility of hability for release	of the above information to the	extent malcated and	
		information. I am the patient or a	m authorized to act on behalf of	the patient to sign this	
		n for the use or disclosure of the pr			
**Our	office uses an outside cor	mpany called HealthPort to proces	s all medical records requests. T	hey will copy your medical	
		ice, if applicable, based on regula			
Signatu	re of the patient		 Date		
	re or the patient				
Signatu	re of legal representative	and relationship to patient	Date		

Date

Signature of witness