ST. JOSEPH PRIMARY CARE

MEDICAL RECORDS RELEASE
AND HIPPA DISCLOSURE

4400 Falls of Neuse Rd., Suite 101 | Raleigh, NC 27609
(919) 386-6866 | Fax: (919) 386-6867

Patient Name_____ DOB _____ MR#_____

Social Security _____ Telephone _____

I, authorize _____

To release/obtain: ☐ My entire medical record for all dates of service inclusive of any drug, alcohol, or HIV information.

☐ My entire medical record for specific date(s) _____

You are hereby authorized to furnish all my protected health information to:

☐ Primary Care Office: ST. JOSEPH PRIMARY CARE
4400 FALLS OF NEUSE RD., SUITE 101
RALEIGH, NC 27609

☐ Facility to receive/obtain information _____

☐ Spouse_____ ☐ Child_____

☐ Legal Guardian/Power of Attorney _____

This information is being disclosed for the following purpose: _____

_____

_____

I understand that:

I may revoke this Authorization at any time:
The revocation will not apply to information that has already been released in response to this Authorization. I must revoke this Authorization in writing to:

I may refuse to sign this Authorization:
By doing so this will have no effect on the condition of my treatment or eligibility to receive service.

A fee may be charged for copying the protected health information.

I have been informed and understand the information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law. Unless otherwise revoked, this authorization will not expire.

_____ _____
Patient/Legal Guardian/Power of Attorney's Signature **Date**

_____ _____
Witness's Signature **Date**