3150 Rogers Road, Suite 101
Wake Forest, North Carolina 27587
P: (919)504-4000 F: (984)235-1250

RELEASE OF MEDICAL RECORD INFORMATION

Release to Family First Primary Care

This authorization expires ninety (90) days from date of signature

PATIENT NAME____ DOB_____________________

Reason for Request: ______ Medical (continuing care) ______Personal

______ Medical (transferring care) ______ Other

I hereby authorize the following clinician/facility and staff to disclose my protected health information to Family First Primary Care:

1. The following person, or facility may release my protected health information.
   Name ____
   Address____
   Phone (______)__________________________ Fax (______) ______________________________

2. Complete Record _______________ Partial Record_________________ through_____________

ATTENTION: UNLESS YOU SIGN HERE, NO INFORMATION MAY BE RELEASED REGARDING ALCOHOL OR SUBSTANCE ABUSE, **HIV/AIDS**, OR MENTAL HEALTH. **YES**, DISCLOSE THIS INFORMATION ___________________________________.
SIGNATURE
_________________ **NO. DO NOT** DISCLOSE THIS INFORMATION.

3. I understand that my protected health information may be re-disclosed by the person/facility receiving it, and would at that time no longer be protected by federal privacy regulations.
4. This authorization expires ninety (90) days from date of signature or sooner, (1) if at any time I should revoke it, or (2) upon the occurrence of the following expiration event for which this disclosure was authorized.
5. Please FAX all records to**: Family First Primary Care at (984)235-1250**.

____ Date_____________________

Signature of Patient/Guardian or Representative

Description of representative's authority to act for patient____