First Choice Community Health Centers
Angier Medical
84 Medical Drive
Angier, NC 27501
Phone: (919) 639-2122 Fax: (919) 639-8685

PATIENT INFORMATION REQUEST FORM

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Date (s) of Service: _____

INFORMATION TO BE RELEASED:

— Lab Reports
— History / Physical Exam
— Office / Progress Notes
— X-Ray / Sono / MRI Reports
— Consult Notes
— Operative Records
— Other _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, the above-identified patient, or my legal representative, hereby authorizes use or disclosure of protected health information, all records, x-rays, abstracts and excerpts of all records, mental health records and/or evaluations, and any other information which you may possess relating to the examination, diagnosis, prognosis, care of treatment, billing or opinions rendered concerning any and all conditions that the above-identified Patient has had in the past, may have now, and may have in the future. I understand that all information used or disclosed may be subject to re-disclosure by the First Choice Community Health Centers d/b/a Boone Trail Medical and would then no longer be protected by federal privacy regulations.

I authorize the use of photo-static reproductions of the same extent of the original, and I authorize the use of this medical release and reproduction thereof to satisfy all State/Federal regulations for the release of confidential records as pertains to mental health evaluations/diagnosis', including, but not limited to psychological, psychiatric, or physical impairment, drug/alcohol use, AIDS/HIV, etc. All records faxed and received are stored in a secure location. All records faxed to the above number will be protected/secured according to the regulations of HIPAA. I may revoke this authorization by notifying First Choice Community Health Centers d/b/a Angier Medical in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.

This authorization expires on _____.

I hereby certify that I am the above identified Patient and do hereby authorize the below Provider to release my record in accordance with this authorization.

This the _____ day of _____, 2_____.

_____
Signature of Applicant

WITNESS:

-OR-

_____
FCCHC Representative

_____
Signature of Authorized Representative

This information is needed and is voluntarily disclosed by me **to be released from**:

_____
Agency Name

_____
Agency Address

_____
Agency Phone # Agency Fax #