Revolution Patients:

Please complete the following form in it's entirety, to prevent delay in care.

Some tips:

Social security number is not absolutely required. It may make it easier to find your records at a large medical institution, especially if the records are several years old, but you may choose to leave the SSN blank.

Please include UP TO three physician/practices that may have helpful records. Please **cross out** the unused physician/practice blanks.

Please check the boxes for
"all healthcare records" AND
"all records pertaining to mental health"
unless you want to restrict the type of records sent to me.
(It is fine to restrict records, if desired!)

Check "yes" for STD lab results, unless you wish to restrict that information.

If sending this form back to me via email, by taking a photo, please make sure you take the photo in very good light, such as strong sunlight.

Revolution Family Medicine

56 N Broad St E
Angier. NC 27501

Authorization to Release Healthcare Information

Patient Name: ____ Date of Birth: ______________________

Previous Name: _____________________________________ Social Security #: ________________________

I request and authorize:

Physician/Practice #1:

Name: ____ Phone: _______________________

Address: ____

Physician/Practice #2:

Name: ____ Phone: _______________________

Address: ____

Physician/Practice #3:

Name: ____ Phone: _______________________

Address: ____

to release healthcare information of the patient named above to:

C Revolution Family Medicine, PLLC
Broad St E, Angier, NC 27501
Phone 209-265-8805 Fax 910-500-6191

For the purpose of: ________continuity of care____

This request and authorization applies to:

❏ All healthcare information

❏ Healthcare information relating to the following treatment, condition, or dates:

____

❏ All records pertaining to mental health and substance abuse excepting content of counseling sessions

Other ____

I authorize the release of my STD* results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV(Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

❏ Yes ❏ No

Patient Signature: ____ Date Signed: ____________________

This authorization expires ninety days after it is signed.