Open Door Clinic of
Alamance County

MEDICAL RECORDS RELEASE AND HIPAA DISCLOSURE

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Patient Name____ DOB _______________ MR#_________________

Last 4 Digits of SS # _______________ Telephone ____________________________

Check the appropriate box:

☐ I authorize Open Door Clinic of Alamance County to **OBTAIN** records from my previous health care provider.

☐ I authorize the **RELEASE** of my medical records from Open Door Clinic of Alamance County.

☐ I authorize Open Door Clinic of Alamance County to **DISCUSS** my care with _________________________________

Office to obtain records from/release records to:

Office Name & Address ____

Phone: ______________________

Fax: ________________________

This information is to be disclosed for the purpose of:

☐ Continuity of Care ☐ Personal Use ☐ Legal Representation ☐ Two-Way Communication ☐ Other: _________________

Information to be disclosed:

☐ Release my medical records from ____________________ (start date) to ___________________________ (end date).

Information to disclose (check all that apply):

☐ Office Progress Notes ☐ Lab Results ☐ Medication List ☐ Immunization Record ☐ Mental Health Treatment Records

☐ Psychiatric Evaluations ☐ Dates of Service(s) ☐ Other: ____

☐ Release my entire medical record for all dates of service inclusive of any drug, alcohol or HIV information.

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 Open Door Clinic of Alamance County. 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 expire in one year from date of signature.

Patient/Power of Attorney's Signature: ____ **Date:** _________________

Witness' Signature: ____ **Date:** _________________