ID CARE®
INFECTIOUS DISEASES SPECIALTY PRACTICE
P 910.729.6552
F 910.500.1002
WWW.IDCAREPA.COM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

Patient Name	Date of Birth

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name	Facility Phone	Facility Fax

Facility Address

Dates and Type of Information to Disclose:	Purpose of Disclosure is:
☐ Medical Record (Past & Present) ☐ Dates_____ ☐ Specific Information Requested_____ _____	☐ Change of Insurance or ☐ Physician Continuation of Care ☐ Referral ☐ Other_____

RESTRICTIONS: Only medical records originate through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

Release to the following individual or organization: (Please Fax or Mail Records)

ID Care® - Infectious Diseases Specialty Practice
1319 Avon Street Fayetteville, NC 28304
821 S Horner Blvd. Ste. C Sanford, NC 27330
1700 S Tarboro St. Ste 202 Wilson, NC 27893
Phone: 910.729.6552 Fax: 910.500.1002

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____**
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative — Date

_____ _____
Print name of Authorized Representative — Relationship to Patient