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

PATIENT REGISTRATION

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone	Cell Phone		
Gender ☐ M ☐ F	SSN	Email	
Primary Care Provider	Referring Provider		

Emergency Contact (for minor child, this section may be used for legal guardian)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone	Cell Phone		

I/We do hereby consent to and authorize the performance of all treatments, procedures and medical services deemed advisable by the physicians and staff of the ID Care® to me or to the above-named minor or person of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize my ID Care® to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until canceled by me in writing. I certify that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient/Responsible Party | Date

_____ _____

Name of Patient/Responsible Party | Relationship to Patient

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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 organization: (Please Fax or Mail Records)
ID Care® - Infectious Diseases Specialty Practice
Phone: 910.729.6552 Fax: 910.500.1002 Email: info@idcarepa.com

☐ **FAYETTEVILLE**
1319 AVON ST
FAYETTEVILLE NC 28304

☐ **SANFORD**
821 S HORNER BLVD STE C
SANFORD NC 27330

☐ **WILSON**
1700 TARBORO ST SW STE
202 WILSON NC 27893

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