CARTERET OB-GYN ASSOCIATES
3511 John Platt Drive • Morehead City, NC 28557 • (252) 247-4297
666 West Corbett Avenue • Swansboro, NC 28584 • (910) 325-8612
Fax (252) 247-7383 • Email carteretobgyn@embarqmail.com

Authorization to Release Medical Information

Patient's Name:_____**Date of Birth:**_____

Patient's Address:_____

Last Four of SS#:_____**Daytime Phone Number**_____

☐ **Obtain From** ☐ **Send To**	☐ **Obtain From** ☐**Send To**
Carteret Ob-Gyn Associates	Name/Office: _____
3511 John Platt Drive	Address: _____
Morehead City, NC 28557	_____
P (252)247-4297/ F (252) 247-7383	Phone: _____
Requesting Provider _____	Fax: _____

Reason for Request:

☐ Transfer of Care ☐ Referral Appointment

☐ Continuity of Care ☐ Other: _____

☐ Disclose the following records:_____

Date range of disclosure: From_____ To_____

Select preferred format:

☐ Paper
- ☐ Mail to above address
- ☐ Will pick up at practice

☐ Electronically
- ☐ CD
- ☐ Patient Portal
- ☐ Email (Password:_____)

☐ Fax Number: _____

- Email Address:_____
- For **email communication**, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. By providing my email address I elect to receive email communication as requested.

☐ I do hereby consent and authorize you to release copies of my records, including current and previous medical records from both Carteret Ob-Gyn Associates as well as third party facilities. This authorization includes consent for release of alcohol, drug, psychiatric, pregnancy, sexually transmitted diseases, HIV testing, AIDS, cancer, and cancer testing in my record. I agree that a copy of this authorization or a fax of this authorization shall be as valid as the original.

Note: This authorization will expire on _____

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that the first set of records is a courtesy and any subsequent sets I will be charged a processing fee. Please allow 7 to 10 days for processing.

_____ _____ _____
Signature of Patient or Personal Representative **Date** **Witness**

Note: Attach necessary documentation of Personal Representative's Authority

Updated 11/14/17