

3511 John Platt Drive
Morehead City, NC 28557
Phone 252-247-4297
Fax 252-247-7383



668 W. Corbett Avenue
Swansboro, NC 28584
Phone 910-325-8612
Fax 910-325-8615

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**

Carteret Ob-Gyn Associates

3511 John Platt Drive

Morehead City, NC 28557

P (252)247-4297/ F (252) 247-7383

Requesting Provider _____

☐ **Obtain From** ☐ **Send To**

Name/Office: _____

Address: _____

Phone: _____

Fax: _____

Reason for Request:

- ☐ Transfer of Care ☐ Referral Appointment ☐ Moving*
☐ Continuity of Care ☐ Other: _____ ☐ Unsatisfied with current care*

Select preferred format:

☐ Paper ☐ Email address: _____ ☐ Fax Number _____

☐ Disclose the following records: _____

Date range of disclosure: From _____ To _____

☐ Cancel all my future appointments with this facility.

☐ Do NOT cancel any future appointments until I have scheduled care with another facility. I will notify this office when I have scheduled with another facility.

☐ 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 9/7/23