



Phone 919-788-4444  
Fax 919-788-4464

## Authorization for Disclosure of Health Information

I, the undersigned, authorize **Centre OB/GYN 4414 Lake Boone Trail, Suite 205 Raleigh, NC 27607** to release my health information as noted below: Please return the **COMPLETED** authorization to this address.

### Patient Information

**\*\*\*All sections must be completed in order for request to be processed\*\*\***

Patient Full Name: \_\_\_\_\_ Other Names During Treatment? \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Email Address: \_\_\_\_\_

### Release Information To: (THIS SECTION MUST BE COMPLETED)

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_  
Purpose of Request:  Referral by WHA to Another Provider  Second Opinion OR Transfer of Care to Another Physician  
 Personal Records  Other/Reason \_\_\_\_\_

### Information to be Released

#### Please specify the information to be released:

Office Notes  Labs  Operative Notes  Diagnostic Reports

Specify Date(s) of Service: \_\_\_\_\_

Entire Chart

**\*\*\* PAYMENT OPTIONS: Check, Credit Card or Money Order**  
Charges outlined below will be applied for all copies released directly to patient or sent on patient behalf.

**\*Invoice must be paid before records will be released.**

**\*\*North Carolina Statute §90-411:** \$0.75 for first 25 pages, \$0.50 for pages 26 - 100, \$0.25 for pages over 100, **Minimum fee of \$10.00.**



Initial Here

\*\*I understand BACTES Imaging will MAIL an invoice for records per North Carolina Statutes and payment is made directly to BACTES Imaging. Questions about your request or invoice can be answered by calling: (877) 270-4365

### Authorization to Release Protected Health Information

**\*Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one

Initial each line below

I DO  DO NOT want information about **\*Mental Health** released \_\_\_\_\_  
 I DO  DO NOT want information about **\*HIV Tests & Related Information** released \_\_\_\_\_  
 I DO  DO NOT want information about **\*Alcohol and/or Substance Abuse** released \_\_\_\_\_  
 I DO  DO NOT want information about \_\_\_\_\_ released \_\_\_\_\_

"Other sensitive information?"



Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete we may be unable to fulfill this request.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(Required for all patients 18 years and older.)

Signature of Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Practice Privacy Officer in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Centre is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.

Rev. 2/15

Records Request FROM Centre