Cabarrus Rowan Community Health Centers, Inc.

MEDICAL RECORD RELEASE FORM

Please complete the following information:

Patient's Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

City _____ State/Zip Code: _____

Information disclose From:

Name: _____

Address: _____

City: _____State___ Zip_____

Phone : _____

Fax : _____

Information disclose To:

Name: _____

Address: _____

City: _____State___ Zip_____

Phone : _____

Fax : _____

Information to be disclosed

Date(s) of Service to Disclose: _____

I understand that my name, date of birth, address, age, gender, phone number; other demographic and insurance information will be included in any release of health or billing information.

____Progress/Office Notes ____ History & Physical ____ Discharge Summary ____ Consultation Notes
____Lab/pathology records ____ X-ray/radiology records ____ Nursing Notes ____ Emergency Notes
____ECG/EEG/Cardiac Catheter ____ Other (specify) _____

This authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, name of healthcare personnel, dates of hospitalization and ambulatory visits. It also includes any information that may be related to drug, alcohol, and psychiatric conditions; specifically ask us not to disclose it in the exclusion section below:

Exclusions: _____

Why Is this information being disclosed? ☐ At request of patient ☐ Continuing Treatment ☐ Worker's Comp ☐ Disability Determination ☐ Legal Investigation ☐ Other_____

Method of Disclosure? ☐ Paper copies mailed ☐ Picked up ☐ Faxed ☐ Electronic ☐ Other_____

Information for the patient or Representative:

1. I understand that I may refuse to sign this authorization.
2. I understand that I have the right to change my mind. I may revoke this authorization by submitting a written request to the Director of the facility where I am sending this authorization.
3. I understand that that the person or organization that gets the information may not be covered by federal privacy rules and may re-disclose this information.
4. I understand that this release is valid for one year from the date I signed. I have read and understand this information.

_____ _____

Signature of Patient (or patient's Representative) Date Signed

Staff Signature/Title/Date

_____ _____

Print Name of Patient Representative

Representative's authority to sign for patient
(i.e., parent, guardian, power of attorney, executor)

McGill Family Medicine
202D McGill Avenue, NW
Concord, NC 28025-4615
704-792-2242
Fax 844-269-8197

Logan Family Medicine
298 Lincoln Street, SW
Concord, NC 28025-5469
704-792-2313
Fax 844-277-4887

China Grove Family Medicine
307 East Thom St.
China Grove, NC 28023
704-855-5200
Fax 844-220-3692

Northern Rowan Family Medicine
300 North Salisbury Ave.
Spencer, NC 28159-2514
704-216-2630
Fax 844-269-7077

Salisbury Health Center
330 Jake Alexander Blvd., W.
Ste. 103
Salisbury, NC 28147
704-519-2366
Fax 844-666-4596