Metro Internal Medicine P.A.
Facsimile Transmittal Sheet
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AUTHORIZATION TO RELEASE MEDICAL RECORDS AND PATIENT INFORMATION

All sections must be completed.

Patient's Name: _____ Birthdate: _____

Street Address: _____ Social Security #: _____

City, State, Zip: _____ Phone #: (home) _____

Maiden/Other Names: _____ (work) _____

I authorize **Metro Internal Medicine** (*circle all that apply*) to **release** / **receive** (*circle one*) information in my patient records as directed below:

1. **Name and address** of person or organization **to** / **from** (*circle one*) whom disclosure is to be made:
   Name: _____ Phone #: _____

   Address (City, State, Zip): _____
2. **Purpose** of disclosure (*please specify*): _____
   (e.g., Patient's request, Patient evaluation)
3. **Dates** of Service: From _____ To _____
4. **Specific provider's records** to be disclosed: _____
   (name of facility)
5. **Revocation/Expiration.** This authorization can be revoked in writing at any time unless the provider marked above have already acted upon your request. All requests/instructions must be in writing, dated and signed.
6. **Fees.** There may be a fee associated with the processing of this request. Please check with the staff for estimated costs. The providers marked above frequently contract with third party vendors for confidential record copy services, so the bill for records copied may be generated by a third party vendor.
7. **Important Notice** **THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS ARE PROTECTED BY NORTH NORTH CAROLINA AND FEDERAL LAWS AND REGULATIONS. THE CONFIDENTIALITY LAWS AND REGULATIONS PROHIBITED THE DISCLOSURE OF THESE RECORDS *UNLESS*:**

   1. **THE PATIENT CONSENTS IN WRITING;**
   2. **THE DISCLOSURE IS ALLOWED BY A COURT ORDER;**
   3. **THE DISCLOSURE IS MADE TO MEDICAL PERSONNEL IN A MEDICAL EMERGENCY OR TO QUALIFIED PERSONNEL FOR RESEARCH, AUDIT, OR PROGRAM EVALUATION. VIOLATION OF THE LAWS AND REGULATIONS IS A CRIME. SUSPECTED VIOLATIONS MAY BE REPORTED TO APPROPRIATE AUTHORITIES IN ACCORDANCE WITH THE LAWS AND REGULATIONS. FEDERAL LAWS AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT SUSPECTED CHILD ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW TO APPROPRIATE STATE OR LOCAL AUTHORITIES.**

My authorization to disclose the above information is voluntary, and the providers marked above will not condition the provision of treatment on this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by the laws and regulations applicable to the providers marked above.

_____ _____
Authority to Sign, if not the Patient Date

Copy to patient

Records to be: ☐Mailed ☐Faxed ☐Picked up