Medical Records Release Authorization

Clinical Research of Gastonia
1010 X Ray Drive
Gastonia, NC 28054
704-675-7144 (Phone)
704-671-2322 (Fax)

Please do not bill patient for copying of medical records

Date of Request: _____/_____/_____

I, _____ (patient name), am writing to authorize Clinical Research of Gastonia to obtain my medical records on my behalf. Please release my entire copy of medical records (from the dates listed below) including but not limited to medical reports, clinical and nurse's notes, history of injury, subjective and objective complaints, x-rays, interpretation of a diagnostic test, (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records or logs, physical examination reports, laboratory reports, operative reports, progress notes, doctors orders, physical therapy records, admission and discharge summary reports, medication administration records, all outpatient records, and any other document, records or information in your possession relative to my past, present, or future physical and mental conditions related to treatment for all medical conditions rendered by you or under your supervision.

Records requesting, including the following dates:	through
From (Name of Facility)	
Address	
Phone/Fax	
Patient's full name	
Other names used, if any	
Patient's SS# /Date of birth	

Please send to the attention of: _____ at the above address or fax number. Thank you for your prompt attention.

Patient Information:

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 redisclosure by the recipient and may no longer be protected by federal or state law.*

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 I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Dr. Mikell Jarratt.

I understand released information may include a communicable disease diagnosis such as HIV.

_____ _____

Patient signature **Date**

This authorization is valid for one year from date of request unless specified elsewhere on this form
Revised: Aug 2015