

Mill Creek Family Practice

J. Seaborn Blair III, MD

Joseph Farmer PA-C, Amber Lawrence, FNP-C

94 Merchants Circle Ste. 100

Hampstead, NC 28443

Ph: (910)270-2515 Fax: (910)270-3544

REQUEST FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize _____ Ph: _____ Fax: _____

to release confidential medical information to:

Mill Creek Family Practice

Fax #: 910-270-3544

William J. Mattox, M.D., Joseph S. Farmer, PA-C, Amber Lawrence, FNP

Please send what is indicated below for cont. of care for our mutual patient, as to provide excellent medical care, thank you.

Office notes:	X
Labs:	X
Radiology:	X
Other:	X

Comments/Requests:

I give permission for my medical information to be released to Mill Creek Family Practice. I understand and knowledge this may include alcohol/drug abuse, mental health, or HIV/AIDS information. I understand that I revoke this authorization at any time, except to the extent that the action has already been taken to comply with it. The requestor should not re-disclose my medical records to another party without further written consent.

Signature: _____ Date: _____
(Patient or patient representative signature)