Mill Creek Family Practice

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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

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)