

KERNERSVILLE PRIMARY CARE

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

FOR A COMPLETE AND ACCURATE MEDICAL RECORD FOR MY PRIMARY CARE PHYSICIAN LISTED BELOW, I WISH TO REQUEST AND AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION, INCLUDING ANY HOSPITAL MEDICAL RECORD, IMMUNIZATIONS, LABORATORY VALUES, X-RAY REPORTS, PATHOLOGY REPORTS AND A RECORD OF ANY MEDICAL TREATMENT REPORTS. THIS INCLUDES INFORMATION PERTINENT TO MENTAL HEALTH, DRUG/ALCOHOL ABUSE AND HIV/AIDS. THESE MEDICAL RECORDS MAY BE RELEASED TO MY PHYSICIAN WHILE I AM A PATIENT AT KERNERSVILLE PRIMARY CARE.

**RELEASE TO: KERNERSVILLE PRIMARY CARE
 WILLIAM S. KELLY, M.D.
 STEPHANIE L. TAYLOR, PA-C**

PATIENT IDENTIFICATION

NAME _____
 FIRST MIDDLE LAST

ADDRESS

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

PATIENT SIGNATURE OR LEGAL GUARDIAN

WITNESS SIGNATURE

ALL INFORMATION RELEASED WILL BE HELD AS PROTECTED HEALTH INFORMATION. I UNDERSTAND I MAY REVOKE THIS CONSENT AT ANY TIME

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