Request for release of medical information

I authorize: ____

____

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____

Phone: _________________**Fax:** _________________

to release to**: Synergy Family Medicine**
122 Timberhill Place
Chapel Hill, North Carolina 27517
Phone: (919) 869-3188 Fax: (919) 869-3178

The medical record of:

Patient Name: ____
Date of Birth: ______________ Social Security #: _______________
Address: ____
City: _______________________ State: ___________ Zip: _________

Information to be released: the most recent ____ year(s) of record of

___office visit notes ___lab reports ___pathology reports ___radiology reports

I acknowledge that the data to be released **<u>may include</u>** material that is protected by law. My initials and my signature below authorize release of the following type of information

____ drug/alcohol abuse information ____ mental health information
____ HIV information ____ genetic testing

_____________________________________ ______________
Signature of Patient Date

_____________________________________ _______________
Signature of patient's parent/legal representative Date

Relationship to patient____________________