

Request for release of medical information

I authorize: _____

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 **may include** 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 _____