

Medical Record Release Form

I, authorize: _____ (name of medical office)
_____ (street address)
_____ (city and state)

Phone: _____ Fax: _____

to release my medical records to:

Synergy Family Medicine
118-D Old Durham Road
Chapel Hill, North Carolina 27517
Phone: (919) 869-3188 Fax: (919) 869-3178

Medical record of:

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Information to be released:

Most recent two years of record: problem medication summary sheet, immunization sheet, lab reports, physical exam form, office visit notes, radiology reports (ultrasound, CT, and MRI).

Or

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