Integrative Medical Clinic of North Carolina
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INTEGRATIVE MEDICAL CLINIC
of North Carolina

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone: (___)_____

I hereby authorize Integrative Medical Clinic of North Carolina to release the following health information about me to the following health care professional, medical facility, mental health facility, laboratory, medical examiner, medical records service, employer, or family member:

Person/Organization to Receive Information: _____

Address: _____

Phone Number:_____ Fax Number:_____

Information to be Released:

- **Office Notes**
- **Lab Results**
- **Operative Notes**
- **Diagnostic Reports**
- **Entire chart**
- **Other**

Treatment Dates: From:_____ to _____ --OR-- All Treatment Dates

I understand that I may revoke this Authorization in writing at any time, except to the extent that the action has already been taken in response to the Authorization. I understand that federal or state law may restrict redisclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may decline to sign this Authorization. Refusal to sign this Authorization will not adversely affect the Integrative Medical Clinic of North Carolina's ability to provide treatment and seek payment for services provided. This authorization expires one year from the signed date listed below unless otherwise revoked:

Patient Signature: _____ Date:_____