AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ALL AMERICAN ASSOCIATES IN FAMILY MEDICINE

Date: _____

This authorization is for _____ to release information being
(Name of Previous Clinic)
requested of you, by you in order to comply with the terms of the Confidentiality of Medical Information Act.

Patient Name: _____
Birth Date: _____
Daytime Phone Number:_____
Social Security Number: _____

I Hereby Authorize: Clinic Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone number: (____) _____ Fax number: (_____) _____

To Release Information To: **AAA All American Associates in Family Medicine, PLLC**
1750 Metromedical Drive
Fayetteville, NC 28304
Phone (910) 339-1446
Fax (877) 500-1463
MedicalRecords@AAAFamilyMedicine.com

This release limits disclosure to:

All Records ☐ Labs ☐ X-Ray Reports ☐ Immunizations ☐ Consult Notes ☐

Other: _____

Information not to be released (if any): _____

A specific authorization is required to release information regarding the following:

HIV Information: Yes ☐ No ☐ **Initials** _____
Drug/Alcohol information: Yes ☐ No ☐ **Initials** _____
Mental Health Information: Yes ☐ No ☐ **Initials** _____

This information is required for: Change of Provider

Other (please specify): _____

This authorization will be valid until _____ (please indicate a date after which no information may be released. If no date is given, consent will be valid for 1 year)

I may revoke this authorization at any time, in writing, before the information has been released. I authorize the transmittal of this information via the selected transmittal format and release AAA All American Associates in Family Medicine, PLLC from liability for breach of confidentiality, misdirection, or failure to receive transmission.

FAX ☐ E-mail ☐ Electronic Media ☐ All three ☐ **Initials** _____

Patient Signature: _____

Parent, Guardian, or Authorized Representative: _____

Witness: _____