Clayton Medical Associates, P.A.
100 Guy Road
Clayton, NC 27520
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DR. JOAN N. MEEHAN
BOARD CERTIFIED
FAMILY PRACTICE

DEBORAH B. ROBERSON, FNP-C
BOARD CERTIFIED
FAMILY NURSE PRACTITIONER

ALYSSIA LLOYD, FNP-BC
BOARD CERTIFIED
FAMILY NURSE PRACTITIONER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
(Print patients full name) (Birth date (Mo./Day/Yr.)

_____ _____
(Street Address) Social Security Number

_____ _____
(City, state, zip code) Home phone number

Please specify information requested to be released:

___Office Notes ___Pathology Reports ___ED reports
___H&P, Discharge notes ___Lab Reports ___Other
___OP Notes ___Radiology Reports ___EKG/Cardiac Reports

From the time period of _____to _____

____I do _____I do **NOT** authorize release information related to AIDS or HIV infection, psychiatric care and/or psychological assessment, and treatment for drug and/or alcohol abuse.

INFORMATION RELEASE FROM:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

_____
Phone Number

RELEASE TO:

Clayton Medical Associates

100 Guy Road

Clayton, NC 27520

919-553-3900

PURPOSE OF DISCLOSURE:

___Referral to Specialist ___Insurance Application ___Workers Comp ___Change of MD
___Attorney Request ___Disability Determination ___Personal ___Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for _____ from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or entity receiving it and would no longer be protected by federal regulations. I understand that the medical provider to whom this information is furnished may not condition its treatment of me on whether or not I sign this authorization.

_____
Signature of Patient (or responsible party) **Date**