MCDUFFIE MEDICAL ASSOCIATES, PC

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Patient Name: ______________________________ Date of Birth: ___/___/___ Phone #: _________________

Address: ____

I authorize the release of medical information as indicated below:

FROM:	**To:**
Name: ___________________________________	Name: ____________________________________
Address: _________________________________	Address: __________________________________
Phone/Fax: _______________________________	Phone/Fax: ________________________________

☐ I would like to pick up my records, call me at the above number.
☐ I would like records to be mailed to me at above address.
☐ I would like my records to be fax to the above number.

What to Release, Please choose the records you would like released:

☐ ALL medical records	☐ Outpatient notes	☐ Laboratory reports	☐ Pathology report(s)
☐ X-ray report(s)	☐ Immunization record	☐ Other Specify: ____________________________	

NOTE: The records listed below have special protection by law. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV test	☐ Yes	☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	☐ Yes	☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	☐ Yes	☐ No/NA

Purpose of the release: Please indicate the reason for the release: ☐ For another doctor
☐ To obtain disability ☐ Use in lawsuit ☐ Worker's care ☐ Other:_________________________________

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:
☐ Please change the expiration date to last for __________ days.

I understand this Authorization can be revoked at any time according to McDuffie Medical Associates privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signed this authorization.

Once these records are released, the information is not protected by McDuffie Medical Associates and may potentially be re-disclosed by the party who received there records. McDuffie Medical Associates, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

____   ______________________

Signature of patient or legal representative and relationship to patient   Date

____   ______________________

Signature of witness   Date