Authorization for Release/ Request of Information

For questions, please contact us at (919) 833-3111

Patient Name: ____
Last | First | MI | *Maiden or Other Name*

Date of Birth (mm/dd/yyyy): ______________ My Advance Community Health Site: ____________________________

Request Records from:
I hereby request my medical/dental records from:

Name: ____________________________________ Address: ____

City: ___________________________________ State: _________ Zip: ___________ Fax: _______________________

Release Records to:
I hereby authorize Advance Community Health to release medical/dental records as indicated below to:

Name: ____ Address: ____

City: ___________________________________ State: _________ Zip: ___________ Fax: _______________________

Information to be Requested/Released:
(choose one)

- ☐ Dates of Service: ___________________ to ___________________
- ☐ All of my dates of service

Include:

- ☐ Office visits
- ☐ Lab reports
- ☐ Immunizations
- ☐ Other: ____

Purpose of Disclosure *(choose one):*

- ☐ Changing provider
- ☐ School
- ☐ Consultation/second opinion
- ☐ Workers' Compensation
- ☐ Continuing care/referral
- ☐ Insurance
- ☐ Legal
- ☐ Personal
- ☐ Other: ________________________________

I specifically authorize the release of information related to:

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental health (including psychotherapy notes)
- ☐ STD, HIV, and HIV related information (including STD testing)
- ☐ None of the above

Sign: ______________________________________ _______________
Signature of patient or parent/guardian Date

I am the (choose one):

- ☐ Patient
- ☐ Parent/guardian
- ☐ Authorized person
- ☐ Other: ________________________________

1. I understand that I may revoke this authorization at any time by notifying the providing organization in writing.
2. I understand that the information used or disclosed by signing this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

____ ____ _____________
Requesting Person Name | Requesting Person Signature | Date

____ ____ _____________
ACH Employee Witness Name | ACH Employee Witness Signature | Date