



PO Box 837
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Voice 910 383 1500
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

TO _____

Fax _____

Address _____

I do hereby consent to authorize Batish Family Medicine, LLC to receive/release copies of my medical records disclosing information relating to my identity, diagnosis, prognosis, and/or treatment. I understand that this authorization is voluntary. I understand if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations. I understand that the medical information released may include alcohol or drug abuse, psychiatric/mental health, HIV diagnostic, and/or other sensitive documentation.

I AUTHORIZE BATISH FAMILY MEDICINE TO RECEIVE/RELEASE MEDICAL INFORMATION FROM THE RECORDS OF:

Patient Name _____

Date of Birth _____ Social Security # _____

INFORMATION TO BE DISCLOSED

- Health and Medical Records
- Immunization Records
- Laboratory Results
- Radiology Reports
- Other
- Birth Records/History
- Admission/Discharge Summary
- Progress Notes

REASON FOR REQUEST

- ESTABLISH CARE
- CONTINUATION OF CARE
- TRANSFER OF CARE

I UNDERSTAND THIS AUTHORIZATION WILL EXPIRE IN NINETY (90) DAYS.

Patient _____ Date _____

(PRINT PATIENT NAME)

Signature _____ Relationship _____

(IF MINOR, SIGNATURE OF PARENT OR GUARDIAN)

Witness _____ Date _____

(BATISH FAMILY MEDICINE, LLC)