



RELEASE OF MEDICAL RECORD INFORMATION

*This authorization expires **one year** from date of signature*

PATIENT NAME: _____ **DOB:** _____

I hereby authorize the facility / clinician and staff indicated below to disclose my protected health information to:

GENERATIONS FAMILY PRACTICE, PA.

1021 Darrington Dr, Ste 101, Cary, NC 27513 Phone: 919.852.3999 Fax: 919.378.9114

Facility Name / Clinician releasing records: _____

Address: _____

Phone: _____ Fax: _____

REASON FOR REQUEST: Medical (continuing care w/ specialist) Personal
 Medical (transferring / leaving practice) Other: _____

INFORMATION BEING RELEASED:

_____ **Complete Record**

_____ **Partial Record**

Information requested: _____

Dates requested: _____ thru _____

_____ ****DO NOT INCLUDE** information regarding alcohol / substance abuse (in compliance with 42 GFR Part 2), genetic testing, mental health, HIV/AIDS and other sexually transmitted diseases

PATIENT'S RIGHTS – I understand that:

1. I can cancel my permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or Generations Family Practice. Any cancellation will apply only to information not yet release by facility or practice.
2. This is a full release including information regarding alcohol/substance abuse (in compliance with 42 GFP, Part 2), genetic testing, mental health, HIV/AIDS & other sexually transmitted diseases unless indicated above.
3. GFP will not share or use my health information without my permission other than listed in the GFP Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at generationsfamilypractice.com.
4. A fee may be charged for providing my protected health information.

Signature of Patient / Guardian or Representative

Date

Description of representative's authority to act for patient _____