Jacksonville Children's and Multispecialty Clinic
120 Memorial Drive, Jacksonville, NC 28546
910-353-0581 Fax: 910-353-1536

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

_____

AUTHORIZATION:

I hereby authorize Jacksonville Children's and Multispecialty Clinic to release/disclose the above named individual's health information to:

Release From:
Name (Agency): Jacksonville Children's/Multispecialty
Address: 120 Memorial Drive
Jacksonville, NC 28546
Phone: (910) 353-0581
Fax: (910) 939-5802

Release To:
Name (Agency): _____
Address:_____
_____
Phone: ( ) _____
Fax: ( )_____

Information to be released/ disclosed:

_____ Entire Health Record _____ Office Visits _____ Reports (Labs, X-Ray, etc) _____Medications _____ Imm Record
Specific Dates of Service: _____

Please produce records via: _____ Mail _____Fax _____ Pick Up

PURPOSE

_____ Continuity of Medical Care
_____ Insurance or Other Third Party Reimbursement
_____ Not satisfied with medical care
_____ Other (Specify) _____
_____ Disability
_____ Pending Legal Action
_____ Moving out of the area

I understand that the information in my medical record may include information relating to sexually transmitted disease and/or acquired immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above.

RESTRICTIONS

According to the Federal and State regulations, if the medical information requested relates to AIDS/ HIV treatment or treatment in a federally recognized chemical dependency unit then the information will be accompanied with a statement limiting disclosure to third parties as required by law.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that although the Jacksonville Children's and Multispecialty Clinic has the responsibility to maintain the confidentiality of the medical records in its possession, I understand that once the information is disclosed the recipient may redisclose it and federal privacy laws or regulations may not protect the information. Jacksonville Children's and Multispecialty Clinic will not be held responsible for any subsequent disclosure by the recipient of the health information. I release the Jacksonville Children's and Multispecialty Clinic of any liability, which may arise as a result of any subsequent disclosure of my personal health information by the recipient.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility of benefits.

I have read and understand the Jacksonville Children's and Multispecialty Clinic's policy on releasing my personal health information.

DURATION

This authorization will remain valid until _____. I understand that I have a right to revoke this authorization at any time by submitting a written revocation to Jacksonville Children's and Multispecialty Clinic.

SIGNATURE

Patient Signature: _____ Date: _____

Personal/ Legal Representative Signature: _____

If signed by Personal/ Legal Representative, relationship to Patient: _____

JCMC Representative: _____ Date: _____