



Avance Care, P.A.  
6402 McCrimmon Pkwy, Suite 100  
Morrisville, NC 27560  
Ph. (919) 655-1000 Fax. (919) 655-1001

### AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone \_\_\_\_\_ Email: \_\_\_\_\_ (mm/dd/yyyy)

**I request a copy or summary of the following medical records:**

- Complete Medical Record\*     Immunization Record\*     Lab Report(s)     X-ray Reports  
 Electrocardiogram     Allergy Records     Surgical Procedures     Other \_\_\_\_\_

**\*Required if transferring records to Avance Care**

For dates of service from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Purpose of Release:**

- Transfer of care     Moving out of area     Specialist consultation     Legal     Personal  
 Insurance Claim     Workers' Compensation Claim     Other \_\_\_\_\_

- Request to transfer records **FROM the office** listed below to Avance Care, P.A.  
 Request to transfer records **FROM Avance Care, P.A.** to the office listed below

- Please allow 15 days for processing. Incomplete information will delay processing.

Office Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient or Legal Guardian*

### AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize Avance Care, P.A., it's staff and providers to disclose my protected health information to the following representative:

Representative Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
*(full name)*

Protected health information I, the patient listed above, allow to be disclosed to the above representative or organization includes:

- All information** – clinic notes, treatments, past medical history, lab and test results, and information that may pertain to HIV status, mental health, and substance abuse/dependence.  
 **Select Information:** \_\_\_\_\_

This authorization is **valid for one year unless specified:** \_\_\_\_\_

**Please read the following:** You have the right to revoke this authorization at anytime by notifying Avance Care, P.A., 6402 McCrimmon Pwky. Suite 100, Morrisville, NC, 27560 in writing. The revocation will be effective on the date notified and will not apply to all information that has already been released in response to this authorization. Avance Care, P.A., it's staff or providers may deny access to protected health information to the above representative in certain situations and conditions. If denied access, Avance Care, P.A. will notify the patient in writing the reason for denial if requested.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_