Avance Care

Leesville Primary Care (919) 865-8000 Fax. (919) 865-8020
12341 Strickland Rd, Ste 102, Raleigh, NC 27613

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

AvanceCare.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: ____/____/_____
Phone _____ Email: _____ (mm/dd/yyyy)

Legal Guardian name: _____ Relationship to Patient: _____

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 _____

Release To/From: (Select one)

☐ Request to transfer records **FROM the office** listed below to

- ☐ Leesville Primary Care: 12341 Strickland Rd, Ste 102, Raleigh, NC 27613 FAX (919) 865-8020
- ☐ Avance Family Care: 6402 McCrimmon Pkwy, Ste 100, Morrisville, NC 27560 FAX (919) 655-1001

☐ 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: _____

- I understand that my health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol and/or drug abuse. Accordingly, I specifically authorize release of the following information:
  - ☐ Yes ☐ No Mental health and/or psychiatric treatment records
  - ☐ Yes ☐ No Substance abuse (drug and/or alcohol) treatment records
  - ☐ Yes ☐ No Sexually transmitted disease information
  - ☐ Yes ☐ No HIV/AIDS – related information
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that such a revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
  If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days.

Signature: _____ **Date:** _____

Patient or Legal Guardian