CENTER FOR DIGESTIVE DISEASES
AND CARY ENDOSCOPY CENTER, PC
1120 SE CARY PARKWAY STE. 204
CARY, NC 27518
PHONE (919) 854-0041
FAX (919) 854-0049

_____ _____
(Print patient's full name) Birthdate (mo/day/yr)

_____ _____
(Street Address) (Social Security Number)

_____ _____
(City, State, Zip Code) Phone (home)

At the request of the individual, I _____do hereby authorize:

_____
(name of facility or provider)

_____
(street address, city, state, zip)

_____
(fax number)

To release the following: (Please check all that apply)

____ **All Records**
____History & Physical
____Progress Notes
____Operative Notes
___Pathology Reports
___Laboratory Reports
___Radiology Reports
___ECG/EEG/Cardio Cath
____Emergency Reports
____ Discharge Summary
Other_____

____I do ____I do **NOT** authorize release of information related to AIDS (Acquire Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or abuse.

Information released to: Center for Digestive Diseases
1120 SE Cary Parkway, Ste. 204
Cary, NC 27518
(919) 854-0041(phone) (919) 854-0049 (fax)

Purpose of Disclosure:

____Referral to specialist _____Insurance _____Workers Compensation _____Change of Doctor

____Legal Investigation _____Disability Determination _____Continuing Care

____ Permanent Transfer to another GI ____Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized or furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate Date

The maximum fee for each request shall be 75 cents per page for the first 25 pages, 50 cents per pages for pages 26-100 , and 25 cents for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to $10.00, inclusive of copying costs. (*N.C. GEN. STAT. S 90-411 (2004)* **)**