Regenesis MD
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Raleigh, NC 27613
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info@regenesismd.com

MEDICAL RELEASE OF INFORMATION

Patient Name:_____ **Date of birth:**_____

Patient Address:_____

Phone Number:_____

I request and authorize Regenesis MD to release/receive medical record information to/from:

Facility name:_____

Fax Number:_____

Phone Number:_____

Address:_____

_____

Reason for release (Circle one): Transfer of care----Continuation of care----Other

This request and authorization applies to: (initial appropriate line)

____ Healthcare information relating to the following treatment and/or dates of service:

_____

Healthcare information relating to HIV/AIDs testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use (circle one): **Include** **Exclude**

By signing below, I give permission to the above names organization to release information; I understand I have the right to revoke this authorization by providing a written request to do so, and that the revocation will not apply to information that has already been released. I also understand that unless otherwise revoked, this will expire 1 year from the date signed.

_____ _____
Signature of patient or authorized representative Date

_____
Relationship if not signed by patient

I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.