**Metro Internal Medicine P.A.**

**Facsimile Transmittal Sheet**

**Dr Kenneth A. Holt, MD**

**AUTHORIZATION TO RELEASE MEDICAL RECORDS AND PATIENT INFORMATION**

All sections must be completed.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maiden/Other Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize **Metro Internal Medicine** (*circle all that apply*) to **release** / **receive** (*circle one*) information in my patient records as directed below:

1. **Name and address** of person or organization **to** / **from** (*circle one*) whom disclosure is to be made:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (City, State, and Zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. **Purpose** of disclosure (*please specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(e.g., Patient’s request, Patient evaluation)

3. **Dates** of Service: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. **Specific provider’s records** to be disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of facility)

5. **Revocation/Expiration.** This authorization can be revoked in writing at any time unless the provider marked

Above have already acted upon your request. All requests/instructions must be in writing, dated and signed.

6. **Fees.** There may be a fee associated with the processing of this request. Please check with the staff for

Estimated costs. The providers marked above frequently contract with third party vendors for confidential record

Copy services, so the bill for records copied may be generated by a third party vendor.

7. **Important THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS ARE PROTECTED BY NORTH**

Notice NORTH CAROLINA AND FEDERAL LAWS AND REGULATIONS. THE CONFIDENTIALITY LAWS AND

REGULATIONS PROHIBITED THE DISCLOSURE OF THESE RECORDS UNLESS:

1. THE PATIENT CONSENTS IN WRITING;

2. THE DISCLOSURE IS ALLOWED BY A COURT ORDER;

3. THE DISCLOSURE IS MADE TO MEDICAL PERSONNEL IN A MEDICAL EMERGENCY OR TO QUALIFIED PERSONNEL

FOR RESEARCH, AUDIT, OR PROGRAM EVALUATION. VIOLATION OF THE LAWS AND REGULATIONS IS A CRIME.

SUSPECTED VIOLATIONS MAY BE REPORTED TO APPROPRIATE AUTHORITIES IN ACCORDANCE WITH THE LAWS

AND REGULATIONS. FEDERAL LAWS AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT

SUSPECTED CHILD ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW TO APPROPRIATE STATE OR

LOCAL AUTHORITIES.

My authorization to disclose the above information is voluntary, and the providers marked above will not condition the

Provision of treatment on this authorization. I further understand that information disclosed pursuant to this

Authorization may be subject to disclosure by the recipient and is no longer protected by the laws and regulations

Applicable to the providers marked above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority to Sign, if not the Patient Date

Copy to patient

Records to be:

Mailed Faxed Picked up