Paul F. Meyer, MD
Ben Wilson, MD
Ruffin Morgan, P.A. –C

Sundara Rajan, MD
Lissa Domenech, P.A.-C
Lauren Lyerly, P.A.-C

Authorization for Release of Medical Information

Date: _____ **Date of Birth**:_____

I, _____
(Print patient's name)
Authorize: _____
(Name of Physician or Hospital)
_____
(Address)
_____ _____
(Phone number) (Fax number)
To release the following information from my medical record:
{ } Transfer of Care
{ } Last (18) Eighteen Months
{ } Acute Care
{ } specific information (dates needed)_____
{ } Mental Health Care or Services
{ } AIDS or HIV Testing
{ } Narcotic Medications
{ } Other (specify) _____
Purpose: _____
To: Lexington Family Physicians, PA_____
(Name of Physician, Hospital, Other)
102 West Medical Park Drive-Lexington, NC 27292_____
(Address)
336-249-3329_____ 336-249-3795_____
(Phone number) (Fax number)
Signature: _____ Date: _____
(patient, or authorized representative)
Address of Patient: _____
_____
Telephone number: _____
Witness: _____ Date: _____

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing or shall remain in effect for the period reasonable needed to complete the request. The patient or the patients authorized representative is entitled to receive a copy of this form.
I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected under law.