W. Stanley Rule, M.D., F.A.A.P
Pediatrics and Adolescent Medicine
3604 Medical Park Court
Morehead City, NC 28557
252-240-5437
252-240-3084 FAX

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient_____Medical Record Number_____

Date of Birth_____Social Security Number_____

Patient Address_____
Street Address City State Zip Code

Patient Phone Number_____
Primary Secondary

I authorize the following health care provider or facility to **DISCLOSE** my patient information:
Name of Health Care Provider or Facility:_____
Phone Number:_____ Fax Number:_____
Address:_____
Street Address City State Zip Code

I authorize the following health care provider or facility to **RECEIVE** my patient information:
Name of Health Care Provider or Facility:_____Dr. W. Stanley Rule _____
Phone Number:_(252) 240-5437_____Fax Number:_(252) 240-3084_____
Address:_3604 Medical Park Court____Morehead City____NC____28557__
Street Address City State Zip Code

Reason for Transfer:_____

Please disclose the following information:

- ☐ In-Patient
- ☐ Out-Patient
- ☐ Doctor's Notes
- ☐ Correspondence
- ☐ Treatment
- ☐ Laboratory and Pathological Tests
- ☐ Examinations and Analyses
- ☐ Surgical and Non-Surgical Procedures
- ☐ Diagnosis and Prognosis
- ☐ Immunizations
- ☐ History of Billing and Charges

I understand that this authorization included consent for the release of alcohol, drug, psychiatric, and physiological information. It also includes any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS related syndromes. It may also include any information concerning cancer, cancer testing, and cancer results.
I understand the medical provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

I have been informed that the requestor will not release any information about me to any person or agency other than those stated above. With a signature, this authorization will be valid for 12 months.

I understand I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to the releasing provider.

I hereby do authorize you to release copies of my medical records or my child's medical record.

_____ _____
Signature of Patient or Legal Guardian Date