Midway Medical Center, PA

6750 Carolina Blvd
Clyde NC 28721
Phone: (828) 627-2211 Fax (828) 627-2216

30 N Main St.
Canton NC 2876
Phone: (828) 646-0080

PATIENT INFORMATION:

_____ _____
Last Name First Name MI Date of Birth

_____ _____
Street Address/Apt# (Include Complete Mailing Address) Social Security #

_____ _____
City State Zip Code Phone Number

SEND RECORDS TO: MIDWAY MEDICAL CENTER, PA 6750 CAROLINA BLVD, CLYDE NC 28721

RELEASE AND DISCLOSE MY RECORDS FROM: (Name of Physician/Organization to Obtain Medical Records)

_____ _____
Name of Physician or Organization Fax Number

_____ _____
Street Address (Complete Mailing Address) Telephone Number

_____
City State Zip Code

Treatment Date(s) to be use/disclosed: From_____ to _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) PROVIDED

☐ Summary of Medical Records for personal or physician use ☐Complete Medical Record
"OR" SPECIFIC DOCUMENT(S) TO BE DISCLOSED FOR THE ABOVED TREATMENT DATE(S) PROVIDED:
☐ Office Notes ☐ Laboratory Report(s) ☐ Diagnostic Test/Report(s) ☐ Consultation(s)
☐ Operative Reports ☐ Radiology Report(s) ☐ Pathology Report(s) ☐ other, specify _____

This information may include Medical/Surgical, Psychiatric, Substance Abuse, and HIV/AIDS information.
SPECIFIC INFORMATION NOT TO BE DISCLOSED: _____

THIS INFORMATION IS TO BE USED/DISCLOSED FOR THE FOLLOWING PURPOSE(S): (check all that apply): ☐ Continuation of Care ☐ Patient Transfer ☐ Insurance ☐ Legal ☐Other Explain _____

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- Unless withdrawn, this consent will expire 90 days from the date signed unless another date or even is specified.
  _____
- I understand that the purpose of this authorization is for the use/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the Privacy Officer at Midway Medical Center, PA. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my PHI have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature

_____ _____
Signature of Patient Date

_____ _____
Signature of Personal Representative and Authority to Sign Date

_____ _____
Witness Date