

MIDWAY MEDICAL CENTER  
Family Medicine



RECORDS MAY BE FAXED TO: 1-855-876-9354

OR MAILED TO: MIDWAY MEDICAL CENTER, 6750 CAROLINA BLVD, CLYDE, NC 28721

## Patient Information:

_____ Last Name	_____ First Name	_____ MI	_____ Maiden Name	_____ Date of Birth
_____ Street Address/APT # (Include Complete Mailing Address)				_____ Social Security #
_____ City	_____ State	_____ Zip Code		_____ Phone Number

## Release and Disclose My Records From:

1			
_____ Name of Physician/Organization	_____ Phone Number	_____ Fax Number	
_____ Street Address, City, State, Zip Code			
2			
_____ Name of Physician/Organization	_____ Phone Number	_____ Fax Number	
_____ Street Address, City, State, Zip Code			
3			
_____ Name of Physician/Organization	_____ Phone Number	_____ Fax Number	
_____ Street Address, City, State, Zip Code			

### Description of Information to be Disclosed for Treatment Date(s) provided:

- Summary of medical records for personal or physician use - last two (2) years of records
 **OR**
 Office Notes
  Consultations
  Substance Abuse
  Radiology reports
  Laboratory reports
  Other, specify \_\_\_\_\_
  Psychological/Psychiatric conditions
  Operative reports

Treatment date(s) to be disclosed - **FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

Specify information NOT to be disclosed:  Psychological/Psychiatric conditions  Substance Abuse  AIDS/HIV/STDs

This information is to be used/disclosed for the following purpose(s) - (check all that apply)

- Continuation of care
  Insurance
  Legal
  Patient transfer
  Other (please explain) \_\_\_\_\_

I hereby authorize the healthcare provider, facility, or organization(s) listed above, to disclose to Midway Medical Center and its affiliates all requested medical records, including any specially protected records such as those related to psychological or psychiatric conditions, drug or alcohol use, sickle cell anemia, or HIV infection, unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand that I may revoke this authorization at any time by providing written notice; however, such revocation will not affect any information released prior to receipt of the notification. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PERSONAL REPRESENTATIVE AND AUTHORITY TO SIGN

\_\_\_\_\_  
DATE