Angier Pediatrics and Adult Medical Center, PLLC
Kingsley C. Ugochukwu, M.D.
441 Lakestone Commons Avenue, PO Box 517
Fuquay-Varina, NC 27526+6972
(919) 577-0481 (office) (919) 577-0512 (fax)

Authorization for Release/Request for Medical Information

Patient Name:_____ Date of Birth:____/__/_____

Social Security #:_____ Previous Name:_____

Home Phone:_____ Other Phone:_____

Address, City, State, Zip:_____

I request and authorize _____
Name of Practice Office # Fax #
to release the medical record of the above-named patient to:

Name of Practice: Angier Pediatrics and Adult Medical Center, PLLC

Address: PO Box 517, Fuquay-Varina, NC 27526+0517

Office Phone: 919-577-0481

Reason For Release (check one): [ ] Transfer [ ] Continuity of Care [ ] Referral [ ] Other _____

This request and authorization applies to: (Initial appropriate line)

1. _____ Health Care Information relation to the following treatment condition or dates of treatment. This *information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.)*

_____

_____

2. _____ All Health Care Information including information relating to hIV/AIDS testing, sexually transmitted diseases, psychiatric disorders, mental health or drug and/or alcohol use.

3. _____ All Health Care Information excluding information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use any radiological studies (MRI, CT, mammograms), any Echo and/or cardiac studies and any Colonoscopy Reports.

I understand that I have the right to revoke this authorization by providing a written request to do so to the above-named physician or organization which I am requesting records from. I understand that this revocation will not apply to information that has already been released.

Unless otherwise revoked, this authorization will expire six (6) months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

I understand that there will be a charge for copying my records, not to exceed the fee-copying limit set by the North Carolina Medical Board.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Representatives Relationship To Patient and Phone Number Date

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ **BY:** _____