Raleigh
Family Practice, P.A.

- Andy C. Babcock, M.D.
- Gary O. Bean, M.D.
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patient's full name) _____ Date of Birth (mo/day/year) _____

(Street Address) _____ Social Security Number _____

(City, State, Zip Code) _____ Phone (Home) _____

I hereby authorize Raleigh Family Practice, P.A to release and/or disclose the following protected Health Information:

_____

_____

_____

_____

For: ☐Continuation of Care or ☐Transfer of care ☐ Other: _____

To: _____

Address: _____

_____

Fax # _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that this information used or disclosed may be subject to re-disclosure by the facility receiving it, and may no longer be protected by federal HIPAA regulations. I understand I have the right to refuse to sign this authorization, and I am not obligated to sign this form in order to received treatment from Raleigh Family Practice, PA.

_____ _____

Signature of patient, guardian, or personal representative Date

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