Raleigh
Family Practice, P.A.

- Andy C. Babcock, 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 _____ to release
(Name of facility)
and/or disclose the following protected Health Information for the purpose of continuity of care: _____
_____
_____
_____

To: Raleigh Family Practice, P.A.
4414 Lake Boone Trail Suite 502
Raleigh, NC 27607

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