

# Authorization to Release Clinical Record Information

Print Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

To: *Capital City Surgery Center* (Institution Holding Records)

Address: *23 Sunnybrook Rd. Suite 100*

City: *Raleigh* State: *North Carolina* Zip: *27610*

***I AUTHORIZE YOU TO RELEASE RECORDS TO:*** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax Number (If applicable): \_\_\_\_\_ Attn: \_\_\_\_\_

**FOR THE PURPOSE OF:** \_\_\_\_\_  
(Reason for Releasing Information)

Release the following portion(s) of patient's medical record during the time period of: \_\_\_\_\_

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Record   | <input type="checkbox"/> Pathology Report     |
| <input type="checkbox"/> Nurse's Notes     | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Progress Notes       |
| <input type="checkbox"/> Lab Report        | <input type="checkbox"/> X-Ray Report       | <input type="checkbox"/> History and Physical |

**ENTIRE MEDICAL RECORD**

This authorization will remain in effect for six months at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by the patient at any time, but it is NOT retroactive to release of information made in good faith.

By signing this authorization, the undersigned agrees NOT to disclose or make copies of indicated information, unless further disclosure is expressly permitted by necessary implication inherent in the purposes of the original consent of authorization.

***Proposed new use of information without additional written consent of the person to whom it pertains is prohibited.***

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information mentioned above. I understand that if there is a charge for copies, that such charges must be paid prior to release of copies.

***If patient is under 18 years of age:***

Patient Signature: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Witness: \_\_\_\_\_

Capital City Surgery Center, LLC  
919-322-4800 phone  
919-231-1473 fax

Account Number: \_\_\_\_\_