Medical Record Release Form

I, authorize: _____ (name of medical office)

_____(street address)

_____ (city and state)

Phone: _____ Fax: _____
to release my medical records to**:**

Synergy Family Medicine
118-D Old Durham Road
Chapel Hill, North Carolina 27517
Phone: (919) 869-3188 Fax: (919) 869-3178

Medical record of:
Patient Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Information to be released:
___Most recent two years of record: problem medication summary sheet, immunization sheet, lab reports, physical exam form, office visit notes, radiology reports (ultrasound, CT, and MRI).
Or
___The most recent ____ year(s) of record of

___office visit notes ___lab reports ___pathology reports ___radiology reports

I acknowledge that the data to be released **may include** material that is protected by law. My initials and my signature below authorize release of the following type of information:
____ drug/alcohol abuse information ____ mental health information
____ HIV information ____ genetic testing

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's parent/legal representative Date