Randy Long, MD
Internal Medicine

114 West Medical Park Drive
Lexington, N.C. 27292
Phone: (336)249-8760 Fax: (336)249-2710

Authorization to Release Health Information

To: _____
(Diagnostic Center, Physician's Office)

Phone Number _____

Fax Number _____

Pursuant to my rights under HIPAA, I hereby request a copy of my Medical Records as a matter of urgency, and hereby authorize you to furnish and complete records prepared or obtained by you within the last 24 months, preferably via Fax Attention to:

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Medical Records should include any and all Medical Information, including but not limited to MRI, X-RAY, Pharmacy Records, and Lab Results. For purposes of this Authorization, medical information specifically includes any confidential information regarding presence of HIV/AIDS, Drug Abuse, Disease, or Mental Health Status. I understand that:

1. I may refuse to sign this authorization that is strictly voluntary.
2. My treatment, payment, and enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by the Federal Privacy Regulation and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee of ($10), if I ask for it.
6. I have kept a copy of this form after signing it.
7. The purpose of the release of these records is healthcare-related.

I have read and hereby authorize the release of this protected health information. This Authorization is Valid for One (1) year from this date set forth below.

Print Name _____ DOB: _____

Patient Signature _____ Date: _____