Southern Surgical Associates, PA
Wade Naziri, MD **William Chapman, MD** **Julie Johannes, PA-C**

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____ Medical Record#:_____

DOB:_____ SSN:_____

Patient Address:_____

Dates of service requested for release: ☐All ☐Date Range: _____to_____

Information to be disclosed:

- ☐ Office Visits
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Consultation Reports
- ☐ Pathology Reports
- ☐ Operative Reports
- ☐ All of the Above

1. I authorize the following health care provider to facility to **DISCLOSE** my patient information:
   Name of Health Care Provider/Facility: Southern Surgical Associates, PA
   Address: 2455 Emerald Place Greenville, NC 27834
   Phone#: 252-758-2224 Fax#: 252-758-2860

2. I authorize the following health care provider or facility to **RECEIVE** my patient information:
   Name of Health Care Provider/Facility:_____
   Address:_____
   Phone#:_____ Fax#:_____

   OR

   ☐ I authorize my patient information to be released to myself (the patient listed above).

3. I understand that this authorization included consent for the release of alcohol, drug, psychological information and any information relating to pregnancy, sexually transmitted disease, HIV testing, AIDS and any AIDS related syndrome. It also includes any information concerning cancer, cancer testing, and cancer results. I understand that psychological reports will only be sent to another healthcare provider and not released to the patient.

4. Reason for Release: ☐Legal ☐Move ☐Consult/Second opinion ☐Personal

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I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to the releasing provider.

I hereby and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. I agree that a copy of this release of a fax of this release shall be valid as the original release.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____ _____
Name of Representative Relationship to the Patient

_____
Witness

OFFICE USE ONLY
Date Records Copied: _____ Copied by:_____
Medical Copies sent via: ☐Mail ☐Patient Pickup ☐Faxed to:_____