AUTHORIZATION TO RELEASE MEDICAL RECORDS TO THE

_____,

A CLINICAL SITE OF THE PRIVATE DIAGNOSTIC CLINIC, PLLC ("PDC")

Patient Name:_____

Social Security Number:_____

Date of Birth_____

Maiden/Alias Names:_____

I authorize and request _____to release information from my health records to the PDC. These records are to be mailed to:

_____

(Specify Address)

or faxed to:_____at fax number: (919)_____-_____

The specific information for the following dates of service: ____/____/____ to ____/____/____

INFORMATION TO BE RELEASED (check the appropriate boxes and include other information where indicated):

! Summary Health Information
(Includes Discharge summary, History and Physical, Radiology, Pathology, Laboratory, and Dictated notes)

! History and Physical (e.g., Doctor visit)
! Discharge Summary
! Operative Report
! Cardiology Records (Stress Test, EKG Test)
! Comprehensive record
! Laboratory Reports
! Radiology Reports
! Emergency Department Reports
! Respiratory Care Records
! Patient Discharge Instructions

! Other:_____
_____
_____
_____

! Information contained in the Patient's medical record related to psychiatric and/or psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date.

! Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse.

THE INFORMATION TO BE RELEASED WILL BE USED FOR HEALTH CARE TREATMENT/CONTINUING MEDICAL CARE/PAYMENT OR HEALTH CARE OPERATIONS

This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the PDC site specified above (See "Specify Address" Section above). Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____ _____ _____

Date | Signature of Patient** or Legal Representative** | Signature of Witness

****If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-Patient's behalf.** By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you am not prohibited by Court Order from having access to the requested medical records.