Dr. Leslie Murphy-MD, P.C.
80 Aviemore Court - Suite B
Pinehurst, NC 28374

Medical Records Release

Patient Name: _____ Date of Birth: _____

Address:_____ SS# _____

_____

Phone #: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below: I, _____, hereby authorize _____ to release the following information:

X Entire Chart of my Medical Records

I do ___ I do not ___ authorize release of information related to AIDS or HIV infection, sexually transmitted diseases, psychiatric care and or psychological assessment, and treatment for alcohol and/or drug abuse.

Release information to:

Dr. Leslie Murphy-MD, P.C.
80 Aviemore Court - Suite B
Pinehurst, NC 28374
Phone: (910) 215-0892

Authorized Private Health Information will be used and disclosed for the following purposes:
I have received a copy of copy of Leslie Murphy-MD, P.C. Notice of Privacy Practices.
I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment payment, enrollment in a health plan or eligibility for benefits. I also understand my signature will be required prior to my request being completed.
Dr. Leslie Murphy-MD, P.C. may use or disclose such protected health information only until expiration date or expiration event relating to the individual or purpose of the use or disclosure.
At all times, I retain the right to revoke this authorization. Such revocation must be submitted in writing to Dr. Leslie Murphy-MD, P.C. - 80 Aviemore Court, Suite B, Pinehurst, NC 28374.
I understand that information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient of such information, and, at that point, the information may no longer be protected under the federal or state confidentiality rules.
This authorization will automatically expire six months from the date signed.
I understand that I may be required to pay a fee for copying these medical records.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patients.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____