



Aegis
Medical
Center

A division of Rao Clinic
1700 Kildaire Farm Road Suite 130
Cary, NC 27518
Telephone: 919-233-0410 Fax: 919-233-0872

Authorization for Release of Medical Records

(Print Patient's Full Name)

____/____/____
(Birth Date (Month/Day/Year))

I, _____, do hereby authorize
(Patient's Name)

_____, _____ to
(Previous Facility Name) (Previous Provider's Name)

release the following records to **Aegis Medical Center.**

All Records Other: _____

Dates of Service: _____

Purpose of Disclosure:

Change of Provider Insurance Other _____

I hereby authorize disclosure of health information for the above name patient. This Authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but it will not affect any information released prior to notification of cancellation.

I understand that the information used or disclosed may not be protected from re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished, may not condition its treatment of me whether or not I sign the authorization. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, psychological or psychiatric conditions or genetic testing this disclosure will include that information. Please notify us if you do not want us to share this information on this release.

*** Copying of medical records and releasing them to your new Provider is at no charge***

**** Medical records requested/released to patient begins at charge of \$35.00.****

(Signature of individual or Guardian)

____/____/____
Month/Day/Year