ST. JOSEPH PRIMARY CARE
a ministry of caring

4400 FALLS OF NEUSE RD., SUITE 101, RALEIGH, NC 27606
MEDICAL CLINIC AT ST. ANN CATHOLIC CHURCH
4057 US 70 BUS. W., CLAYTON, NC 27520
MAIN: (919) 386-6866 **FAX: (919) 386-6867**

MEDICAL RECORDS RELEASE

Patient Name:______________________________________DOB:___________________ MR#_________

Social Security ___________________________________ Telephone:_______________________________

I, authorize (name of the medical facility that you want the medical records release to St. Joseph Primary Care) ☐ WAKEMED ☐ UNC REX HOSPITAL ☐ DUKE UNIVERSITY HEALTH SYSTEM

☐ OTHER
____

To release/obtain:

- ☐ My entire medical record for all dates of _____________________________________
- ☐ My entire medical record for specific date(s) __________________________________
- ☐ Labs, Xray, and Images
- ☐ Others:____

You are hereby authorized to furnish all my protected health information to:

☑ Primary Care Office:

ST. JOSEPH PRIMARY CARE
4400 FALLS OF NEUSE RD., SUITE 101
RALEIGH, NC 27609
Fax: 919-386-6867

This information is being disclosed for the following purpose: ____________________________________

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I understand that:

- ☐ I may revoke this Authorization at any time:
  The revocation will not apply to information that has already been released in response to this Authorization.
- ☐ A fee may be charged for copying the protected health information.

I have been informed and understand the information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law. Unless otherwise revoked, this authorization will not expire.

____ __________

Patient/Legal Guardian/Power of Attorney's Signature **Date**