# KERNERSVILLE PRIMARY CARE

## 420 WEST MOUNTAIN STREET KERNERSVILLE NC 27284

*Family and Geriatric Medicine*

William S. Kelly, MD, FAAFP, CAQ-Geriatrics

Stephanie L Taylor, PA-C, CDE  Nathaniel S. Kelly, MPH, RD, LDN

Katie A. Scott, AGNP-C


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## AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

**FOR A COMPLETE AND ACCURATE MEDICAL RECORD FOR MY PRIMARY HEALTH CARE PROVIDER FOR THE MANAGEMENT OF MY HEALTH I WISH TO REQUEST AND AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION, INCLUDING ANY HOSPITAL MEDICAL RECORD, IMMUNIZATIONS, LABORATORY VALUES, X-RAY REPORTS, PATHOLOGY REPORTS AND A RECORD OF ANY MEDICAL TREATMENT REPORTS. THIS INCLUDES INFORMATION PERTINENT TO MENTAL HEALTH, DRUG/ALCOHOL ABUSE AND HIV/AIDS. THESE MEDICAL RECORDS MAY BE RELEASED TO MY PHYSICIAN OR PRIMARY CARE PROVIDER WHILE I AM A PATIENT AT KERNERSVILLE PRIMARY CARE.**
**Once information is disclosed to others, the information may be re-disclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA**

**A Fee May Be Charged to the Patient For A Complete Copy of Their Medical Record.**
**Authorization will expire upon Patient signature request and or 30 days after the Patient is no longer under our care.**

**RELEASE TO:** **KERNERSVILLE PRIMARY CARE**
**WILLIAM S. KELLY MD, FAAFP, CAQ-GERIATRICS**
**STEPHANIE L.TAYLOR PA-C, DIABETES EDUCATOR**
**KATIE A. SCOTT, AGNP-C**
**NATHANIEL S. KELLY, MPH, RD**

Records requested from: _____

**PATIENT IDENTIFICATION**
**NAME**

_____

**First  Middle  Last**

**DATE OF BIRTH** _____

**SOCIAL SECURITY NUMBER** _____

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**Patient signature or Legal Guardian Signature  Date**

**I MAY REVOKE THIS CONSENT AT ANY TIME**

**Witness signature  Date**

**ALL INFORMATION RELEASED WILL BE HELD AS PROTECTED HEALTH INFORMATION**