JAY FERNANDO, MD
7615 Colony Road, Suite 115
Charlotte, NC 28226
Phone: 704-626-6812
Fax: 704-626-6824

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(Please read carefully and fill out completely)

I AUTHORIZE,

_____
(Name of sending healthcare facility/provider)
Address: _____
_____
Tel #: _____ Fax #: _____

TO RELEASE TO:

Jay Fernando, MD
7615 Colony Rd, Ste 115
Charlotte, NC 28226

1. INFORMATION TO BE RELEASED: ☐ All Progress notes ☐ Lab Reports ☐ X-ray Reports
☐ Immunization Records ☐ Complete Copy of Medical Records ☐ Other _____

2. SPECIAL AUTHORIZATION: (Check applicable items and sign below)
By signing below, I authorize to release any and all information to Jay Fernando, MD regarding: ☐ HIV ☐ AIDS Or AIDS Related

☐ Complex ☐ Mental Health ☐ Drugs ☐ Alcohol ☐ Sexually Transmitted Disease

3. RECORD FROM THE TIME PERIOD: ___/___/_____TO: PRESENT

4. PURPOSE OR NEED FOR DISCLOSURES: (Check applicable purpose)
☐ Continual Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Workers Compensation ☐ Other

5. I understand that disclosure to Workers Compensation of Disability Insurance Carriers removes all privacy protection attached to Protected Health Insurance. I understand that this authorization shall be valid for one year. I understand that I may revoke this authorization at any time by written notice except to the extent that action has already been taken.

6. I understand that a reasonable fee may be charged for duplication of records. An estimate of charges will be provided upon request to prior duplication.

7. The requestor may be provided with a copy of this authorization.

8. If this release pertains to alcohol or drug information, please note that: this information has been disclosed to you from records protected by federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressed permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or persecute any alcohol or drug abuse patient.

9. I understand that medical records in the possession of recipient may be re-disclosed and no longer protected by the privacy rule.

Patients Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip Code: _____

_____ _____ _____
Signature/Relationship to Patient Date Authorized Representative/ Relationship to Patient