Authorization for Release of Information Form

Release To: Keelee J. MacPhee, MD. Plastic & Reconstructive Surgery

5826 Fayetteville Road, Suite 209, Durham, NC 27713

Phone: 919-341-0915 and Fax 919-341-0917

I hereby authorize use or disclosure of protected health information about me as described below:

Patient Legal Name_______________________________________ **Preferred Name**: _____________________

Last 4 digits of SS#: __________________________ **DOB:** ___________

The following person(s) or facility is authorized to make the requested use or disclosure to Dr. MacPhee:

Requested Records Mailed or Faxed from:

PROVIDER Name____

PROVIDER Address____

PROVIDER Phone & Fax ____

Information to be released:

_ Medical Records _ Lab Reports _ Radiology reports

_Hospital/ER records _Prescriptions _Other: _______________________________

Specific description of information to be released:

__Only recent results for the past one year _ All Dates _ Specific date(s):________________________

The information to be released will be used for the purpose described below:

_ Continuing Health Care _ Other: ____

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
- I may revoke or withdraw this authorization by notifying Keelee MacPhee, MD of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions.
- This authorization will expire on Date: ____________ **or** 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Patient Signature:____ Date:_____________________

Signature of Guardian:____Date:_____________________