

SOS Urgent Care
1130 North Church Street
Greensboro, NC 27405
336-235-2663 phone 336-375-2314 fax



AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

Patient's Full Name: _____ Phone: _____
Street Address: _____ Email: _____
City/State/Zip: _____ Date of Birth: _____

Request Information From:

Release Information To:

Name of Company/Agency/Facility/Person

Street Address

City/State/Zip

Phone / Fax

Name of Company/Agency/Facility/Person

Street Address

City/State/Zip

Phone / Fax

Authorize Release of Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse. Yes___ No___

Information Needed For: Attorney___ Insurance Company___ Self___ Other_____

Complete Record _____

Partial Record _____
(Indicate info needed and date range...for example, MRI reports 2006, Op Note from 06-13-07...etc.)

PLEASE NOTE THERE IS A FEE FOR REPRODUCING PATIENT RECORDS. THESE FEES ARE IN ACCORDANCE WITH NC General Statutes 90-411 and are as follows:

- **\$.75 for the first 25 pages**
- **\$.50 for pages 26-100**
- **\$.25 for pages over 100**
- ***Minimum fee of \$10.00**

Authorization will expire in 12 months from date of signature below:

Signature: _____ Witness: _____ Date: _____