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	Name of Company/Agency/Facility/Person
_____	_____
Street Address	Street Address
_____	_____
City/State/Zip	City/State/Zip
_____	_____
Phone / Fax	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: _____