Osteopathic Medical Arts, PC

727 Eastowne Drive, Suite 200A
Chapel Hill, NC 27514
Phone: 919.401.4515 Fax: 919.401.4514

Provider to Provider Records Request

Patient Full Name: _____ **DOB**: ___/___/___

Email address & Last four digits of SS# for Encrypted PDF file _____
** Do not email this form as it is not HIPAA compliant.*

This will authorize:	To release medical records to:
Osteopathic Medical Arts, PC 727 Eastowne Drive, Suite 200A Chapel Hill, NC 27514 Phone: 919.401.4515 Fax: 919.401.4514 (please check at least one box below) ❒ Dr. Thomas M. Motyka, DO ❒ Sally Joseph, MSN, WHNP ❒ Colleen Prince, PA-C	

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- ❒ Complete Records
- ❒ Lab Reports
- ❒ X-Ray Reports
- ❒ X-Ray Films
- ❒ Immunization
- ❒ Other:

_____
_____

Reason for Release:

- ❒ To update my regular doctor (provider)
- ❒ I have been referred to another doctor
- ❒ I want/need a second opinion
- ❒ I am changing doctor (provider)
- ❒ My insurance changed
- ❒ My doctor has moved to another practice and requires my records for continuity of care
- ❒ I am moving (please provide new address)

_____
_____
_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (you **must** mark *yes* or *no*):

Yes	No	
❒	❒	Substance Abuse (alcohol/drug abuse)
❒	❒	Mental Health/Depression (includes psychological testing)
❒	❒	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS: This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Date: ___/___/____ **Signature of Patient or Responsible Party**: _____