

**TRIANGLE COMMUNITY PHYSICIANS, PA**

4309 MEDICAL PARK DRIVE, SUITE 200

DURHAM, NC 27704

Phone: 919-471-4484

Secure Fax: 919-477-6131

Patient name: \_\_\_\_\_

TCP MR#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

☐ Robert C. Pennington, MD,    ☐ John A. Kallianos, MD    ☐ Kombiz P. Klein, DOI Authorize Triangle Community Physicians, PA to ☐ obtain from ☐ release to:\_\_\_\_\_  
Name of Provider/Facility\_\_\_\_\_  
Address\_\_\_\_\_  
City State Zip Code\_\_\_\_\_  
(area code) Telephone Number\_\_\_\_\_  
(area code) Fax number**DATE OF SERVICE:** ☐ ALL or ☐ Specific time frame: \_\_\_\_\_**INFORMATION TO BE RELEASED/OBTAINED (check the appropriate box)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Complete medical record       | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Immunization Records                      |
| <input type="checkbox"/> Office visit note(s)          | <input type="checkbox"/> Radiology reports  | <input type="checkbox"/> Growth Curves                             |
| <input type="checkbox"/> Consultation note(s)          | <input type="checkbox"/> Stress test        | <input type="checkbox"/> Colonoscopy/EGD with Pathology            |
| <input type="checkbox"/> Operative note/procedure note | <input type="checkbox"/> EKG tracing        | <input type="checkbox"/> Psychiatric/psychological consultation(s) |
| <input type="checkbox"/> Other _____                   |   |  |

**PURPOSE OF THIS RELEASE: (Check the appropriate box)**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Transfer care to another practice                              | <input type="checkbox"/> Legal        |
| <input type="checkbox"/> Sharing information with other physicians/health-care entities | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Insurance processing   | <input type="checkbox"/> Other: _____ |

Please note the information contained in the patient's medical record MAY contain information relating to psychiatric/psychological diagnosis, HIV status, AIDS, alcohol use/abuse, drug use/abuse, and/or genetic testing.

**DURATION OF AUTHORIZATION:**

This Authorization will expire on the following date or time frame: \_\_\_\_\_. If no date is specified, this Authorization will expire 1 year from the date signed. This Authorization may be revoked at any time provided the revocation is a properly executed document and delivered to the Triangle Community Physicians, PA practice site. Such revocation shall not affect disclosures prior revocation to the extent that this authorization will be relied upon for such disclosures made prior to the revocation

**MEDICAL RECORD FEES:**

There is a copying/handling charge in accordance with North Carolina General Statutes § 90-411 for copies of the medical record used for personal use, legal use or for permanent transfer to another practice. The rates are as follows: \$0.75 per page for pages 1-25, \$0.50 per page for pages 26-100 and \$0.25 per pages 101 and over. There is a minimum charge of \$10. The fee is payable upon release of the record.

\_\_\_\_\_  
Signature of patient or Legal representative\_\_\_\_\_  
Date\_\_\_\_\_  
Patient's current address\_\_\_\_\_  
Patient current telephone #