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, DO

I 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)

☐ Complete medical record
☐ Office visit note(s)
☐ Consultation note(s)
☐ Operative note/procedure note
☐ Other_____
☐ Laboratory reports
☐ Radiology reports
☐ Stress test
☐ EKG tracing
☐ Immunization Records
☐ Growth Curves
☐ Colonoscopy/EGD with Pathology
☐ Psychiatric/psychological consultation(s)

PURPOSE OF THIS RELEASE: (Check the appropriate box)

☐ Transfer care to another practice
☐ Sharing information with other physicians/health-care entities
☐ Insurance processing
☐ Legal
☐ Personal Use
☐ 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 #