Tandem Primary Care
Individually guided. Holistic minded. Community united.

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the health care provider/person/facility/entity listed below.

PATIENT NAME: _____
Date of Birth: _____ SSN: _____

Release my protected health information FROM the following health care provider/person/ facility/entity and/or those directly associated in my medical care:

Name:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone:_____ Fax:_____

The information you may release subject to this signed release form is as follows:

- Complete Records
- Care Plan
- Pathology Reports
- Hospital Reports
- Other (please specify):
- History & Physical
- Lab Records
- Treatment Record
- Medication Record
- Progress Notes
- Radiology Reports
- Operative Reports

Release my protected health information TO the following health care provider/person/ facility/entity and/or those directly associated in my medical care:

Name: Tandem Primary Care, PLLC
Address:105 Newsom Street, Suite 106, Durham, NC 27704
Phone: 919-321-0418 Fax: 919-321-0401

Signature:_____

_____ _____
Patient Name or Patient Guardian Name /relationship Date