McCRIMMON PRIMARY CARE plus

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PLEASE ALLOW 15 BUSINESS DAYS FOR PROCESSING. INCOMPLETE INFORMATION WILL DELAY PROCESSING.
Please complete this form in its entirety. Not completing the form in its entirety may cause delay in processing of records.

Patient Information

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Transfer Request Details (Select One)

☐ **Request to transfer records TO McCrimmon Primary Care Plus FROM the office listed below:**

*****We Do not accept CD's or Flash Drives. Please fax or mail record*****

□ Morrisville: 6402 McCrimmon Pkwy.#100 Morrisville, NC 27560 (P) (919) 655-1000 (F) 888 355 8929

□ West Cary: 7750 McCrimmon Pkwy.#100 Cary, NC 27519 (P) (919) 234-1577 (F) 888 355 8929

☐ **Request to transfer records FROM McCrimmon Primary Care Plus TO the office listed below.**

☐ **Request to transfer records to myself (patient or legal guardian) for personal use:**

Office Name: _____

☐ Address: _____

☐ Phone/Fax Number: _____

Information to be Released (check all that apply):

☐ Entire Record ☐ Office Notes ☐ Lab Reports ☐ Imaging (X-ray, MRI, etc.) ☐ Immunizations ☐ Other: _____

Purpose of Disclosure: (Select One)

☐ Continuity of Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other: _____

Effective Date of this Request: _____/_____/_____ until: _____/_____/_____

I understand that my health record may include information related to sexually transmitted diseases, AIDS, HIV, behavioral health, and drug/alcohol treatment**.** I understand that I may revoke this authorization at any time by submitting a written. Revocation will not apply to information already released based on this authorization. I understand that once released, information may no longer be protected by HIPAA. I understand that I may refuse to sign this authorization and that it will not affect my treatment, payment, or eligibility for benefits.

Patient/Legal Guardian/Patient Signature _____Date_____

Print Name _____ Relationship: _____

Last Updated: 11/24/2025