AUTHORIZATON FOR RELEASE OF MEDICAL INFORMATION

Lee Ann Roberts, M.D.
leeann.roberts@rdmgpa.com

Patient Name: ____

Maiden or other Surnames used: _________________________ Date of Birth: ___________

Address: ____

City/State/ZIP: ____

Phone: _____________________ Email: _______________________________________

Patient Number (Office Use Only): __________________

Due to the retirement of Lee Ann Roberts, MD I wish to take physical possession of my medical records. Once these records are released the information is not protected by Lee Ann Roberts, MD or Raleigh Durham Medical Associates, and their employees, officers, and attending physicians are released from legal responsibility for the release of the protected health information.

These records may be picked up in person at no charge with advance notice during regular office hours through Dec. 27, 2021 at 5816 Creedmoor Road, Suite 209, Raleigh NC 27612, phone 919-881-7766. By this date records may also be mailed to the patient address above after payment of a $10.00 postage fee. After Jan. 1, 2022 medical records will be in the custody of North Raleigh Pediatrics, 7205 Stonehenge Drive, Raleigh, NC 27613. They can be contacted at 919-848-2249 or nrpeds@rdmgpa.com about obtaining records and payment of any applicable fees.

I have read and understand this information and have kept a copy of this form for my records. I am the patient or authorized to act on behalf of the patient to sign this document verifying authorization for use, disclosure, and release of the protected health information under the above stated terms.

____ ________________________

Signature of patient Date

____ ________________________

Signature of legal representative AND relationship to patient Date

____ ________________________

Witness (if not signed by patient) Date