NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____
SSN: _____

Complete all bolded sections

Select one of the following: ☐ NCDPS to provide copies
☐ NCDPS to obtain copies from _____

Select one box in all sections:

A. Reason for request ☐ Continued care ☐ Insurance ☐ Attorney ☐ Personal use ☐ Other _____

B. Information needed – not all may apply and a fee may be charged

(Check all that apply)

☐ Discharge summary ☐ History & Physical Examination ☐ Psychological/Psychiatric Notes
☐ Lab Report ☐ X-ray Report ☐ Operative Report/Procedure Note
☐ Pathology Report ☐ Office Note (clinic only) ☐ Immunization/Vaccination Records
✓ Substance Abuse – Drug/Alcohol ☐ Other: _____

C. Date of encounter or dates of treatment: _____

D. How to share information

☐ Mail Name: _____
Address: _____
☐ Fax Phone Number: _____
Fax Number including area code: _____
(Faxes will only be for emergency situations and detention centers)

I understand the medical information to be disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault and/or communicable disease including HIV/AIDS. I understand that I may revoke (cancel) this authorization at any time to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I revoke this authorization, I must do so in writing to the Medical Records Section and attach a copy of the release. Unless otherwise revoked, this authorization will automatically expire 1 year after the date signed. I understand that treatment will not be conditioned upon my completion of this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information and would no longer be protected under the terms of the federal privacy rule.

Patient Signature: _____ **Date Signed:** _____

When someone other than patient signs, the following must be completed:

I, _____ (print your name) hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization, and agree that DPS may disclose the medical information of such individual for the purposes set forth.

Signature of Representative: _____ **Date Signed:** _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Executor of Estate ☐ Power of Attorney ☐ Other _____

Reason patient unable to sign: _____

Mail To: NC Dept of Public Safety OR Fax To: 919-715-1581
Medical Records Dept
2405 Alwin Court
Raleigh, NC 27699-4368

File: Document Manager (HERO)
DC-436 (Rev 1/17)

This form is not to be amended, revised or altered without approval of the NCDPS, DAC Medical Director.