CONSENT TO RELEASE MEDICAL INFORMATION

I hereby give permission to _____ to release information from the medical record or disclose person health information for:

_____	_____	_____
Patient Name	Social Security #	Birth date
_____	_____	_____
Purpose of Disclosure	Date of Hospitalization	Telephone #

Circle one of the following choices to indicate the information to be disclosed:

1. A complete copy of my medical record regarding my hospitalization, treatment, or care.
2. All records related to a specified condition: _____
3. Other (List specific information to be released): _____
   _____
   _____

Information to be released to:

Name: Advanced Laparoscopic Associates, P.C.
Joseph C. Moran, M.D., F.A.C.S.
Address: 2801 Blue Ridge Road Suite 101
Raleigh, NC 27607
Telephone # (919) 781-0815 Fax # (919) 781-0816

I understand the personal health information disclosed may include information regarding psychological or psychiatric impairment, substance abuse, Acquired Immunodeficiency Syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). I understand I may revoke this consent at any time except to the extent that the information has already been released pursuant to this consent and before I have revoked my consent. Otherwise, this consent shall continue to be valid only for as long as reasonably necessary to carry out the purposes enumerated above or unless it is with release to an insurance company for payment for medical and/or hospitalization benefits, it would automatically expire 90 days after the date signed, whichever is the earliest date.

_____	_____
Patient/Representative Signature	Date Signed
_____	_____
Relationship to patient	Witness

If you signed as a representative of this patient, read the following and sign below:

I, _____, 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 have read the provisions set forth in this authorization, and agree that Advanced Laparoscopic Associates, PA may disclose the medical record information of such individual for the purpose set forth herein.

_____	_____
Representative Signature	Date Signed

Please note that the information disclosed pursuant to this authorization may be subject to re-disclosure by me/us and would therefore no longer be protected under the terms of the federal privacy rule.