# Onslow Ambulatory Request of Information Form

**Select Specialty Office Below:**

| Central Coast Dermatology | Onslow Ear Nose & Throat | Onslow Internal Medicine & Primary Care | Onslow Pulmonology Associates | Onslow Surgical Clinic |
|---|---|---|---|---|
| Ph.#: (910) 577 – 2334 | Ph.#: (910) 219 – 3377 | Ph.#: (910) 346 – 5016 | Ph.#: (910) 577 – 4968 | Ph.#: (910) 353 – 7848 |
| Fax#: (910) 577 – 2363 | Fax#: (910) 219 – 4227 | Fax#: (910) 346 – 4561 | Fax#: (910) 577 – 2916 | Fax#: (910) 353 – 5052 |

Patients Name: _____ Patient DOB: _____

Previous Name: _____ Last 4 SSN: _____

I request and authorize _____ to release records to the following office for continuity of care:

- ☐ Onslow Pulmonology Associates
- ☐ Onslow Ear, Nose, & Throat
- ☐ Onslow Internal Medicine and Primary Care
- ☐ Onslow Surgical Clinic
- ☐ Central Coast Dermatology

This request and authorization applies to:

- Healthcare information related to the following treatment, condition, or dates: _____
- All Healthcare Information
- Other: _____

**This authorization will Expire: (Choose One)**

- ☐ Two years following death of patient
- ☐ Upon Written Revocation
- ☐ Future Date: _____

By signing I understand:

- I authorize the use/disclosure of my protected health information as described in the document
- I may refuse to sign this authorization and request will be considered null and void
- Onslow Ambulatory Services may not condition my treatment on my refusal to sign this authorization
- I may revoke this authorization at any time by providing written notice of my revocation.

Patient Signature: _____ Date: _____