Carolina Internal Medicine
4 Vanderbilt Park Drive
Suite 100
Asheville, N.C. 28801
Telephone: (828)258-0397
Fax: (828) 258-3390

CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name _____

Patient's Address _____

Patient's Birth Date _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospital, and/or clinics which are a part of my medical records. **PLEASE NOTE:** This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results., I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

- ☐ **SEND ALL OF MY RECORDS**
- ☐ **SEND RECORDS FROM (DATE) _____ TO (DATE) _____**
- ☐ **SEND MY RECORDS PERTAINING TO _____**

_____

SEND RECORDS TO:

_____

_____

_____

REASON FOR REQUEST: _____

_____ _____

Patient's Signature Date

_____

Witness