CAROLINA INTERNAL MEDICINE ASSOCIATES, PA
4 Vanderbilt Park Drive
Suite 100
Asheville, N.C. 28803
PH: (828)258-0397
FAX: (828)258-3390
(Please do not fax records that contain more than 50 Pages)

AUTHORIZATION AND RELEASE OF MEDICAL RECORDS

I voluntarily authorize and request: _____
_____
_____

To release medical information pertaining to:

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: _____

____Request for Entire Medical Record
____Request for Medical Records from (Date) _____ to (Date) _____

The purpose of this request for release of information: ____Transfer of Medical Care
____Authorization to Consult
____Other_____

This information is to be released to: (Please check one)

_____ Kenneth R. Kubitschek, MD, FACP
_____ Frederick C. N. Littleton, MD
_____ Stephen D. Brown, MD
_____ David Clements, MD
_____ Laurie LeMauviel, DO
_____ Mary (Blevins) Smith, MD
_____ Laurie LeMauviel, DO
_____ Pamela B. Cavanaugh, MD
_____ James B. Hoer, MD
_____ Sarah Warren, MD

_____ Catherine A. Haggart, PA-C
_____ Heather M. Hopper, PA-C
_____ Yara White,PA-C
_____ Cristina Searcy, F.N.P.-C
_____ Natalie Ledford, AGNP-BC

I do hereby consent and authorize you to release copies of my personal medical record(s), by fax or mail, including current and previous medical records. Please release copies of all requested information. I hereby release Carolina Internal Medicine from liability of any nature pertaining to the release and use of said medical data or the contents thereof.

_____ _____
Signature of Patient/Legal Guardian/or Next of Kin (Indicate relationship to patient) Date of Request