CAROLINA INTERNAL MEDICINE ASSOCIATES, PA
4 Vanderbilt Park Drive, Suite 100
Asheville, NC 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 Medical Records for the ***last 3 years***
_____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)

___Nathan J. Hruska, MD
___Laurie LeMauviel, DO
___Stephen D. Brown, MD
___David Clements, MD
___James Weaver, MD
___David Reilly, MD
___Alan Morgan, MD
___Joshua Cox, MD
___Gaylon Owens, MD
___Mary (Blevins) Smith, MD
___Pamela B. Cavanaugh, MD
___James B Hoer, MD
___J. David Spivey, MD
___Brian Edwards, MD
___Catherine A. Haggart, PA-C
___Heather Hopper, PA-C
___Kelly Bringle, FNP-C

Note: Offices may charge a fee for records transfers. Any questions regarding this should be directed to the offices that records are being requested from by the patient.

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. I understand the information to be release may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____. 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 Date of Request
(Indicate relationship to patient)