Authorization for Release of Medical Information

Asheville Internal Medicine – 60 Livingston Street, Suite 200, Asheville, NC 28801 Phone: (828) 253-4851 Fax: (828) 252-1969

Today's Date: _____

Patient's Name: _____ Date of Birth:_____

Address: _____

Phone Number: _____ Alternate Phone:_____

Who has the records now?

I hereby authorize: _____ M.D./D.M.D. (circle one)

Physician's Practice: _____

Physician's Address: _____

Physician's Phone: _____ Fax: _____

I authorize release of all of the following information unless specifically checked below:

[ ] Complete Health Records [ ] Pathology Reports

[ ] Progress Notes Only [ ] Consultation Reports

[ ] Laboratory Reports [ ] Other: (Specify) _____ Dates of Treatment:

from: _____ to: _____ **To whom do you wish to release your records to?**

Release to:

Physician's Name: _____ M.D./D.M.D. (circle one)

Physician's Practice: _____

Physician's Address: _____

Phone: _____ Fax: _____

I understand that I may revoke this consent at any time, and that upon fulfillment of the above stated purpose or lapse of twelve (12) months from the date of signature, whichever comes first, this consent will automatically expire without my express revocation, but that revocation may not be applied retroactively once the information has been released in good faith. I understand that Asheville Internal Medicine and its staff and employees cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure and from all legal responsibility or liability that may arise from this authorization.

_____ _____

Signature of Patient or Legal Guardian Witness Signature

If not signed by the patient, please indicate relationship:

[ ] Parent or guardian of minor patient. [ ] Guardian or conservator of an incompetent patient.

[ ] Beneficiary or personal representative of deceased patient.