Asheville Internal Medicine

AUTHORIZATION TO RELEASE PERSONAL AND FINANCIAL INFORMATION

_____ _____

Patient Name Social Security Number

_____ _____

Date of Birth Phone Number

_____ _____

Street Address City, State, Zip Code

I _____ authorize Asheville Internal Medicine to
(Patients Name)
discuss or release my information to (please specify names):

- Parent(s) _____
- Spouse _____
- Children _____
- Guardian _____
- Other _____
(Describe)

I **DO NOT** authorize the release of my personal health or financial information to anyone. _____

Please specify the type(s) of information you would like released to the above named individual(s):

_____ Personal Health
_____ Financial
_____ Appointment

Patient / Guardian Signature: _____
Date: _____