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 discuss or release my
(Patients Name)
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: _____

Effective 04/25/2003
Updated 09/12/2007