ASHEVILLE INTERNAL MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (Print Patients Full Name)

_____ Birth Date (Mo/Day/Yr)

_____ (Street Address)

_____ Social Security Number

_____ (City, State, Zip Code)

_____ Phone (Home)

At the request of the Individual, I _____, do here by authorize
(Patients Name)

_____ to release:
(Name of Facility)

Dates of _____

_____ Discharge Summary
_____ History and Physical
_____ Progress Notes
_____ Pathology Reports
_____ Laboratory Reports
_____ Radiology Reports
_____ ECG/EEG/Cardiac Catherization
_____ Emergency Reports
_____ Other _____

___ I do ____I do NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, PSYCHIATRIC care and/or PSYCHOLOGICAL ASSESSMENT, and treatment for alcohol and/or drug abuse.

☐ **PLEASE CHECK BOX IF YOU ARE TRANSFERRING OUT OF THE PRACTICE**

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

_____ Referral to specialist
_____ Legal Investigation
_____ Continuing Care
_____ Insurance
_____ Disability Determination
_____ Workers Comp
_____ Change of doctor
_____ Personal
_____ Other _____
(Specify)

Please provide a current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me whether or not I sign the authorization.

_____ Signature of individual or guardian or personal representative of patients estates

_____ Date

Note: There will be a charge for a personal copy or the permanent transfer of your records. No records will be sent until payment is made.