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CONSENT FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: ____

Social Security Number:____________________ Date of Birth:______/______/_______

PLEASE RELEASE COPIES OF MY MEDICAL RECORDS
(Please provide complete office/clinical/hospital address plus phone and fax numbers)

FROM:___________________________
____
____
____
____
____
PHONE:__________________________
FAX:_____________________________

TO: (Please check beside your Dr)
____ Dr. Bernstein
____ Dr. Huneycutt
Asheville Medicine & Pediatrics
600 Julian Lane
Suite 630
Arden NC 28704
Fax: (828) 651-0141

Information to be disclosed:
____ All Records
____ Last Visit only
____ All Laboratory Results(including pathology and PAP results)
____ All Radiological Results
____ Other____

All requests for the release of patient information will be valid for one year unless otherwise requested by the patient or legal representative. The signing party maintains the right to revoke authorization of this release(to be done so in writing). Requested patient information will only be released to the person or entity described above.

By signing below, I hereby consent and authorize the release of copies of my medical records, including current and past medical records. This authorization includes consent for the release of alcohol, drug, psychiatric, and psychological information. This authorization also includes information related to pregnancy, sexually transmitted disease, HIV testing and related syndromes. It also includes release of information concerning cancer, cancer testing, cancer testing results. I agree that a copy of this release shall be valid as this original release.

_____________________________________ ______________
(Please Sign) Patient or Legal Representative Today's Date