CONSENT FOR RELEASE OF MEDICAL RECORDS

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Phone: 919-304-5900 Fax: 919-304-5901

From: Patient's Name ____

Patient's DOB ____

Obtain Medical Records From: ____

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I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. This authorization includes consent for the release of alcohol, drug, psychiatric; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS.
It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release or a fax of this release shall be valid as this original release. Please send copies of all restricted information as soon as possible to the address listed.

☐ **Send All My Records**
☐ **Send Records From (date)** ____

☐ **Send Records To:** ____

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______________________________ ______________________________
Patient's (Guardian) Signature Date

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Witness to Signature

☐ Records Faxed Date____________
☐ Records Mailed Date ___________
☐ Records Gave to Patient ________