



CATAWBA VALLEY MEDICAL GROUP

P R I M A R Y C A R E

<input type="checkbox"/> Catawba Valley Family Medicine- Bethlehem p: 828.495.8226 f: 828.495.4191	<input type="checkbox"/> Catawba Valley Family Medicine- Claremont p: 828.459.7324 f: 828.459.7500	<input type="checkbox"/> Catawba Valley Family Medicine- Graystone p: 828.326.9355 f: 828.326.9868	<input type="checkbox"/> Catawba Valley Family Medicine- Long View p: 828.732.5650 f: 828.732.5651	<input type="checkbox"/> Catawba Valley Family Medicine- Maiden p: 828.428.2446 f: 828.428.8226	<input type="checkbox"/> Catawba Valley Family Medicine- Medical Arts p: 828.328.2231 f: 828.328.6170	<input type="checkbox"/> Catawba Valley Family Medicine- Mountain View p: 828.330.0511 f: 828.330.0514	<input type="checkbox"/> Catawba Valley Family Medicine- North Hickory p: 828.326.0658 f: 828.326.7105
<input type="checkbox"/> Catawba Valley Family Medicine- Northeast Hickory p: 828.256.2112 f: 828.256.2393	<input type="checkbox"/> Catawba Valley Family Medicine- Parkway p: 828.212.1020 f: 828.212.1024	<input type="checkbox"/> Catawba Valley Family Medicine- South Hickory p: 828.327.4745 f: 828.322.3569	<input type="checkbox"/> Catawba Valley Family Medicine- Sherrills Ford p: 828.732.5450 f: 828.732.5451	<input type="checkbox"/> Catawba Valley Family Medicine- Taylorsville p: 828.632.7076 f: 828.632.7028	<input type="checkbox"/> Catawba Valley Family Medicine- Viewmont p: 828.324.1699 f: 828.324.0281	<input type="checkbox"/> Catawba Valley Family Medicine- West Mountain View p: 828.672.1101 f: 828.294.0075	<input type="checkbox"/> Catawba Valley Family Care - Newton p: 828.464.7770 f: 828.464.7775

MEDICAL RECORD RELEASE FORM

PATIENT NAME: _____
LAST FIRST MIDDLE MAIDEN

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

I HEREBY AUTHORIZE CATAWBA VALLEY MEDICAL GROUP (PLEASE CHECK ONE):

TO OBTAIN MY RECORDS FROM: _____

FAX # _____ PHONE# _____ ADDRESS _____

TO RELEASE MY RECORDS TO: _____

FAX # _____ PHONE# _____ ADDRESS _____

FOR THE PURPOSE OF (PLEASE CHECK ONE):

- TRANSFER OF CARE
- OTHER (LIST REASON) _____

MEDICAL RECORDS FROM THE FOLLOWING TIME PERIOD ARE TO BE RELEASED:

FROM _____ TO _____
Date Date

INFORMATION REQUESTED INCLUDES (PLEASE CHECK ALL THAT APPLY):

- ALL RECORDS
- DRUG, ALCOHOL TREATMENT RECORDS
- PSYCHIATRIC TREATMENT RECORDS
- AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus)
- OTHER: _____

Right to terminate or revoke authorization: This authorization shall expire (60) days from this date. You may revoke or terminate this authorization by submitting a written revocation to our practice.

Potential for re-disclosure: I understand that once the authorized organization or person receives this information, then this information may be subject to re-disclosure. It may not be possible to ensure your right to protection of the privacy of this information once our practice discloses it to another party.

Effect of refusing authorization: If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Rights of the individual: You have the right to contact and request that your information be protected from anyone that you release your health information to.

Signature of Patient or Patient's Legal Representative and Relationship to the Patient

Date

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