



CATAWBA VALLEY MEDICAL GROUP

S P E C I A L T Y C A R E

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catawba Valley Cardiology	Catawba Valley Vascular Surgery	Catawba Valley Pulmonology	Catawba Valley Foot & Ankle Ctr.
p: 828.326.2354 f: 828.326.2385	p: 828.322.9105 f: 828.328.4999	p: 828.732.5400 f: 828.732.5401	p: 828.855.2131 f: 828.855.2133

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

The information contained in this document is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any distribution or copying of this communication is strictly prohibited. If you receive this communication in error, please notify us immediately. Thank you.