CATAWBA VALLEY MEDICAL GROUP

PRIMARY CARE

Catawba Valley Family Medicine-Bethlehem	Catawba Valley Family Medicine-Claremont	Catawba Valley Family Medicine-Graystone	Catawba Valley Family Medicine-Maiden	Catawba Valley Family Medicine-Medical Arts	Catawba Valley Family Medicine-Mountain View	Catawba Valley Family Medicine-North Hickory
p: 828.495.8226 f: 828.495.4191	p: 828.459.7324 f: 828.459.7500	p: 828.326.9355 f: 828.326.9868	p: 828.428.2446 f: 828.428.8226	p: 828.328.2231 f: 828.328.6170	p: 828.330.0511 f: 828.330.0514	p: 828.326.0658 f: 828.326.7105

Catawba Valley Family Medicine-Northeast Hickory	Catawba Valley Family Medicine-Parkway	Catawba Valley Family Medicine-South Hickory	Catawba Valley Family Medicine-Sherrills Ford	Catawba Valley Family Medicine-Taylorsville	Catawba Valley Family Medicine-Viewmont	Catawba Valley Family Medicine-West Mountain View	Catawba Valley Family Care - Newton
p: 828.256.2112 f: 828.256.2393	p: 828.212.1020 f: 828.212.1024	p: 828.327.4745 f: 828.322.3569	p: 828.732.5450 f: 828.732.5451	p: 828.632.7076 f: 828.632.7028	p: 828.324.1699 f: 828.324.0281	p: 828.672.1101 f: 828.294.0075	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