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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Patient Name: _____ DOB: _____ SS# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No: _____ Fax No: _____

I hereby authorize:

Physician or Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No: _____ Fax No: _____

To release copies of medical records concerning the above patient to:

Physician, Hospital, or Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax No: _____

The type and amount of information to be used or disclosed:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> All Records |
| <input type="checkbox"/> Test Results | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lab Results | |

- Please mail or fax copies to the recipient indicated above.
- I am planning to pick up the copies. Please call me when they have been copied.

I understand the information my health records may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I may revoke this authorization at any time with a written request, except to the extent that action based on this authorization has already been taken. I can read Biltmore Cardiology's Notice of Privacy Practices for more details. **This consent will expire automatically one year for the date on which it was signed.**

X _____ Date: _____
Signature of patient or authorized guardian