PO Box 3710 ● 2406 Century Place SE ● Hickory, NC 28603
(828) 324-9550 ● Fax: (828) 324-4154

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release medical information to include history, physical, pathology reports and radiological reports on:

Name: _____ DOB: _____

Please send information from:

_____

_____

_____

Please send to our office by fax at the following number:

(828) 324-4154

***The intent of requesting these medical records is for my treatment. I understand I may revoke authorization by a written request and also understand that this information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.**

Patient's Signature: _____

Date:_____

*This authorization expires only if and when revoked by person signing