

**NEUSE VALLEY INTERNAL MEDICINE, PLLC**

**701 EXPOSITION PLACE, SUITE 218**

**RALEIGH, NC 27615**

**919-791-2900 (p) 919-845-2568 (f)**

**MEDICAL RECORDS RELEASE REQUEST**

RELEASE MEDICAL RECORDS FROM:

RELEASE MEDICAL RECORDS TO:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_ (Phone)      \_\_\_\_\_ (Fax)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_ (Phone)      \_\_\_\_\_ (Fax)

**PATIENT INFORMATION**

\_\_\_\_\_  
(Print Patient Full Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Patient Date of Birth)

\_\_\_\_\_  
(Daytime Phone #)

\_\_\_\_\_  
(Email address)

**Date Range** \_\_\_\_\_ **to** \_\_\_\_\_

**For the purpose of:**

- All Office Notes
- Lab/Path Reports
- Procedure Reports
- Correspondence
- Cardiology/EKG Reports
- Immunizations
- Radiology Reports
- Other \_\_\_\_\_

- Permanent Transfer to Other Physician
- Insurance
- Referral to specialist
- Personal Copy (charge may apply)

\_\_\_\_ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I do not need to sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_ I understand that information in my health record may include information relating to sexually transmitted disease, AIDS/HIV and other communicable disease, behavioral health, and treatment of alcohol and/or drug abuse.

\_\_\_\_ I understand that I can revoke the authorization at any time, except to the extent that action based on this authorization has already been taken. I understand that if I revoke this authorization I must do so in writing.

\_\_\_\_ I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

\_\_\_\_\_  
(Signature of Patient/Parent/Guardian or Authorized Representative)

\_\_\_\_\_  
Date (This authorization expires 1 yr from today)