THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

FAXED on: __/__/____ by:

Authorization for the Release of Medical Records

Where are the records coming from?

Facility/Doctor's Name:

Phone#: **Fax#:**

Patient Information:

Name: **DOB:** **SSN: XXX-XX-_____**

Address:

City: **State:** **Zip:**

Phone#:

Send medical records to:

Name: **The Family Health Centers, Asheville, Arden, Hominy Valley /** *Medical Records Department*

Provider Name:

Address: **2161 Hendersonville Road**

City: **Arden** State: **NC** Zip: **28704**

Phone#: **828-258-8681** Fax#: **828-253-4830**

Information to be released: ☐ Dates _____ to _____

☐ **All Records** ☐ **Office/Clinic Notes** ☐ **Operative Reports**

☐ **Lab/Pathology Results** ☐ **Radiology Reports** ☐ **Immunization Records**

☐ **Standard New Patient: Last 2 Office Visits, 2 Years Lab & X-ray, Immunizations, Colonoscopy, Last Eye Exam, Patient Summary from EHR. Additional if applies: Last PAP and Mammogram/Consult Notes**

☐ **Other: _____**

If you do not want certain portions of your medical records released, please check the categories listed below you would like **excluded.**

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

☐ **Continuation of Care** ☐ **Transfer to New Physician** ☐ **Other:**

Delivery Method: How would you like the records sent?

☐ **Fax to: 828-253-4830** ☐ **Other:**

Please note that faxing and mailing is not a secure form of communication and may therefore be at risk of being accessible by unauthorized individuals. By signing below, you are acknowledging that you have been made aware of these risks.

Patient's Signature:

I hereby authorize the release of information to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature:	**Date:**
Relationship to patient:	**MR#**