Chatuge Family Practice

241 Church Street; PO Box 1309; Hayesville, NC 28904
Phone: (828) 389-6383 Fax: (844) 689-2560
www.chatugefp.org

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Date: _____

WHO ARE WE GETTING RECORDS FROM?

_____

_____

_____

RE:_____ _____ _____
(Patient Name) (Date of Birth) (Social Security #)

I authorize the release of my or my minor child's records to:
Chatuge Family Practice
PO Box 1309 Phone: (828)389-6383
241 Church Street **Fax: (844) 689-2560**
Hayesville NC 28904

If your office has electronic sending capabilities please email records to cfree@chatugefp.org

*This medical record may contain information about drug abuse, alcoholism, venereal disease, abortion, and/or mental health treatments.

_____ I **DO** consent to have this information disclosed
(Initials)

_____ I **DO NOT** consent to have this information disclosed.
(Initials)

*This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

_____ I **DO** consent to have this information disclosed
(Initials)

_____ I **DO NOT** consent to have this information disclosed.
(Initials)

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed.

_____ _____
(Patient Signature-Parent or Legal Guardian if Minor Child) (Date)

_____
(Witness)

WHICH PROVIDER DO YOU WANT TO SEE:_____
PATIENT CONTACT INFORMATION:_____