

Belmont Medical Associates
1818A Richardson Drive, Reidsville, NC 27320
Phone: (336) 349-5040 Fax: (336) 369-5366

I hereby authorize _____ to release the medical records of:

Patient Name: _____ DOB: ____/____/____ SS# _____ - _____ - _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Date(s) of Treatment Requested: _____

Information to be disclosed (check all that apply)

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Progress Notes Lab | <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Reports | <input type="checkbox"/> X-Ray Reports | |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> EKG/ECG Tests | |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Telephone messages | |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Immunization/Shot records | |

Purpose for the disclosure is :

- Transfer of Care Legal/Insurance Coordination of Care Personal Use Other

Information to be released to:

Recipient's Name: _____

Address: _____

Phone#: _____ Fax #: _____

I do hereby authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are part of my medical records. Please note that this authorization includes consent for the release of alcohol, drug, and psychiatric and psychological treatment information and information relating to pregnancy, STD, HIV testing, AIDS, and any AIDS-related syndromes. It also includes information regarding cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be just as valid as the original release. Please send copies of all requested information as soon as possible.

FEES: I understand and agree that there will be a \$ 10.00 fee associated with the copying of these records.

(Signature of patient or legal guardian)

(Date)

(Witness)

(Date)

FORMAT : _____ Paper _____ CD (HTML)