

Biltmore Family Medicine, PLLC
1 Saint Dunstons Rd
Asheville, NC 28803
828-252-4020 Fax: 828-252-4022

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

From: _____ TO: _____

I, _____, do hereby authorize the release of the following records and/or information with no limitation, which may include treatment for psychiatric illness, alcohol or drug abuse and/or HIV test results for AIDS/ARC diagnoses. Review of the records is authorized.

The purpose of the request is: Continuity of care Legal Matter
 Other Insurance Claim Personal Moving

Information requested:

All Records (from: _____ to _____) or
 Immunization Records Hospital Records Lab Results Specialist report
 Pathology Reports Xray Reports

Patient Name: _____ Date of Birth: _____

Address _____ City, State Zip code _____

Social Security Number _____ Phone Number _____

I understand that this authorization will remain in effect for 60 days from the date of my signature below unless an earlier expiration date is specified in the following space (_____). I also understand that except to the extent that action has been taken on my authorization, I may withdraw this authorization at any time by written notification to all parties involved.

Date: _____ Signature of Patient: _____

If patient is under age of 18 Guardian Signature: _____