Intracoastal Internal Medicine

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910-332-0701
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Medical Records Release From Intracoastal Internal Medicine

I, _____, hereby consent to the release of my medical records from Intracoastal Internal Medicine.

To the following Physician/Facility:

Name: _____

Address: _____
_____

Phone number: _____

Fax number: _____

I authorize the following information to be released:

_____ Entire Medical Records (I understand this includes all labs (including HIV), x-rays, office notes, and information received from other providers unless otherwise specified below.)

_____ Medical Records for date(s) of service: From: _____ To: _____

_____ ONLY the following specific information:
_____
_____
_____

Comments:
_____
_____

I understand the terms of this release, the need for the information, and that there are statutes and regulations protecting the confidentiality of information. I acknowledge that this consent is voluntary and is valid until such request is fulfilled. I further understand that I may revoke consent by giving written notice to the agency with the authority to release the information.

Print Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Patient Signature: _____

Witness: _____ Date: _____