Intracoastal Internal Medicine
2580 Pickard Road
Wilmington, NC 28403
910-332-0701
Fax 910-332-0710

Medical Records Release To The Patient

Print Patient Name: _____

Date of Birth: _____ Social Security 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:
_____
_____

Please forward records to:

_____ Address:
_____
_____

_____ Fax Number: _____

_____ Patient Will Pick Up, Call _____ when ready.

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.

Patient Signature: _____

Witness: ______________________________________ Date: _______________