Community Medical PA
520 W Main Street, Marshville, NC 28103
704 624 3388 phone, 704 624 3390 fax

I give permission to release the health information of:

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN:_____

City, State, Zip: _____ Telephone: ( ) _____

Email address: _____

Release Information From:

_____

_____

_____ (Phone number)

_____ (Fax number)

Release Information To:

_____

_____

_____

(Street Address or PO Box, City, State, Zip Code)

_____ (Phone number)

_____ (Fax number)

PURPOSE OF RELEASE (check reason):

___ Request of individual/personal ____ Continued patient care _____Transfer of Care

___ Insurance _____ Legal purpose including discussions & proceedings Other_____

Fill in dates of treatment for records to be released:

Treatment dates: From _____To _____

Entire record unless otherwise noted below:

_____

DELIVERY METHOD: ____ Reg.US Mail ____ Pick-up ____ Fax, where permitted _____ Overnight/Express Mail Service, where permitted
____ Secure email _____ Other: _____

PATIENT'S RIGHTS – I understand that: I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice. This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases. Community Medical will not share or use my health information without my permission other than by ways listed in our Notice of Privacy Practices or as required by law. A fee may be charged for providing the protected health information. I have a right to receive a copy of this form upon request. This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____

Print Name: _____ Date:_____