JOSHUA NEWTON, PA-C
FAMILY MEDICINE

Medical Record Release Form

All sections of this form MUST be completed before your request can be processed.

Release Medical Records Records From:	**Release Medical Records To:**
Name of Facility	*Name of Facility* The Clinic of Joshua Newton PA-C
Address/City/State/ZIP	*Address/City/State/ZIP* 167 Locust Street, Suite 216 Spruce Pine, NC, 28777
Phone: Fax:	*Phone:*(828) 239-9273 *Fax:* (833) 941-1784

Patient Information

_____ _____
Print Patient's Full Name : Date of Birth:

_____
Address/City/State/ZIP:

_____
Primary Phone #:

Release the following record:

▢ Entire medical record:
▢ Specific Records (specify):_____

Please check beside the options below to authorize the release of sensitive information pertaining to:

▢ Mental Health ▢ Drugs or Alcohol ▢ Genetic Testing ▢ HIV/AIDS/other infectious diseases

Purpose of this Disclosure: _____

I understand that information in health records may include sensitive information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), HIV, and other communicable disease, behavioral health care, and treatment of alcohol and/or drug abuse. My signature releases such information.
I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has already been taken.
I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal laws.

I release The Clinic of Joshua Newton PA-C and its employees form any legal responsibility or liabitliy for the disclosure of the above information to the extent indicated and authorized herein
By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Patient or Legally Authorized Individual Signature: Date:

_____ _____
Name of person signing release Relationship (self/parent/guardian)