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

AUTHORIZTION FOR RELEASE OF MEDICAL INFORMATION

From: _____
_____
_____

TO: BILTMORE FAMILY MEDICINE, PLLC
1 ST. DUNSTANS RD
ASHEVILLE, NC 28803 / FAX: 828-252-4022

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: _____