

VILLAGE INTERNAL MEDICINE

**1843 Quiet Cove
Fayetteville, NC 28304
Phone: 910-483-8080
Fax: 910-484-8030**

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**RELEASE/REQUEST FOR MEDICAL RECORDS FOR USE AND DISCLOSURES RELATED TO TREATMENT,
HEALTHCARE OPERATIONS AND/OR PAYMENT**

Date of Request: _____

Patient Name: _____

SS# or DOB: _____

Please indicate appropriate request below:

_____ I authorize Village Internal Medicine to release my Protected Health Information (Medical Records) to: _____

(If this information is being released directly to you please indicate so. If it is going to a physician office, please include their address or fax number at the bottom of this form)

_____ I authorize, _____, to release my Protected Health Information (medical records) to _____
(Please fill in the physician's name within Village Internal Medicine that you wish these records to come to)

Description of the information to be used or disclosed: (check all that apply)

___ Labs/cytology/pathology: specific date if possible: _____

___ X-rays/radiological imaging: specific type/dates: _____

___ Hospitalization (ER records, H&P, D/C) Specific date: _____

___ Other (specify): _____

___ All records/transfer of care

Mode of Release:

___ Fax the above requested records to 910-484-8030 Attn: _____

___ Mail the above medical records requested to _____

Patient signature: _____ Date: _____