VILLAGE INTERNAL MEDICINE
1843 Quiet Cove
Fayetteville, NC 28304
Phone: 910-483-8080
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RELEASE/REQUEST FOR MEDICAL RECORDS FOR USE AND DISCLOSURES RELATED TO TREATMENT, HEATLHCARE 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 910-480-8030 Attn: _____
_____Mail the above medical records requested to _____

Patient signature: _____Date: _____