



Asheville Head, Neck and Ear Surgeons, P.A.

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CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name: _____
Patient's Address: _____
Patient's Birth Date: _____
Patient's Social Security Number: _____

TO: _____

I, do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-Related Syndromes. It also includes any information concerning Cancer, Cancer Testing, and Cancer Results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

-  SEND ALL MY RECORDS
-  SEND RECORDS FROM (DATE) ____ / ____ / ____ TO (DATE) ____ / ____ / ____
-  SEND RECORDS TO: _____

Please fax to:
PAM
828-255-8033

Patient's Signature

Date

Witness

Done	<input type="checkbox"/>	Initials	<input type="text"/>	Patient ID	<input type="text"/>
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ASHEVILLE

HENDERSONVILLE

MARION