CATAWBA VALLEY MEDICAL GROUP
SPECIALTY CARE

Catawba Valley Cardiology: p - 828.732.5700, f - 828.732.5701
Catawba Valley Vascular Surgery: p - 828.732.5200, f - 828.732.5201
Catawba Valley Pulmonology: p - 828.732.5400, f - 828.732.5401
Catawba Valley Vascular Surgery - Horizon: p: 828.732.7500, f - 828.732.7501
Catawba Valley Foot & Ankle Center: p - 828.732.5530, f - 828.732.5531
Catawba Valley Surgery & Cancer Center.: p - 828.732.7400, f - 828.732.7401
Catawba Valley Neurology: p - 828.732.7600, f - 828.732.7601

MEDICAL RECORD RELEASE FORM

PATIENT NAME:_____
LAST FIRST MIDDLE MAIDEN

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

I HEREBY AUTHORIZE CATAWBA VALLEY MEDICAL GROUP (PLEASE CHECK ONE):

☐ TO OBTAIN MY RECORDS FROM: _____

FAX #_____ PHONE#_____ ADDRESS_____

☐ TO RELEASE MY RECORDS TO: _____

FAX #_____ PHONE#_____ ADDRESS_____

FOR THE PURPOSE OF (PLEASE CHECK ONE):

☐ TRANSFER OF CARE
☐ OTHER (LIST REASON) _____

MEDICAL RECORDS FROM THE FOLLOWING TIME PERIOD ARE TO BE RELEASED:

FROM_____ TO_____
Date Date

INFORMATION REQUESTED INCLUDES (PLEASE CHECK ALL THAT APPLY):

☐ ALL RECORDS
☐ DRUG, ALCOHOL TREATMENT RECORDS
☐ PSYCHIATRIC TREATMENT RECORDS
☐ AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus)
☐ OTHER: _____

Right to terminate or revoke authorization: This authorization shall expire (60) days from this date. You may revoke or terminate this authorization by submitting a written revocation to our practice.

Potential for re-disclosure: I understand that once the authorized organization or person receives this information, then this information may be subject to re-disclosure. It may not be possible to ensure your right to protection of the privacy of this information once our practice discloses it to another party.

Effect of refusing authorization: If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Rights of the individual: You have the right to contact and request that your information be protected from anyone that you release your health information to.

_____ _____
Signature of Patient or Patient's Legal Representative and Relationship to the Patient Date