AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

Patient: _____

Address: _____

Birth Date: _____

SS#: _____

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 part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, and any information concerning cancer, cancer testing, and cancer results. I agree that a copy of the release or a fax of this release shall be as valid as the original release.

____ **SEND ALL RECORDS**

____ **SEND RECORDS FROM (Date)_____to(Date)_____**

____ (Other) _____

Send All Records To: **Viewmont Internal Medicine**
Michael M. Hirsch, M.D., FACP
Elizabeth D. Cressy, M.D
1375 4th Street Drive NW
Hickory, NC 28601
Phone: 828-322-1213
Fax: 828-322-9192

Patient Signature: _____

Date: _____

Witness: _____