AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____

_____

_____

Patient: _____**Birth Date:** _____

____ SEND ALL RECORDS

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

Most recent:

_____ EKG _____ Immunization Record

_____ Labs: (_____-_____)

_____ Clinical Notes/H&P (_____-_____)

_____ All Diagnostic Test Results (radiology/colonoscopy& pathology, mammograms, etc.)

____ (Other) _____

Send Records to:

Viewmont Internal Medicine
Michael M. Hirsch, MD & Elizabeth D. Cressy, M.D
1375 4th Street Drive NW, Hickory, NC 28601
Phone: 828-322-1213 Fax: 828-322-9192

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.

Patient Signature: _____Date: _____

Witness: _____