

Medical Records Release

Patient Name: _____

Social Security Number _____

Phone Number () _____

Date of Birth: _____ / _____ / _____

Reason for transfer/copy _____

I authorize and request: _____

(Name of physician and complete address)

To release to: _____

(Name of physician and complete address)

Information and copies of my medical records, test, diagnosis and treatment to cover the periods of _____

This may also include my test reports, diagnosis and/or treatment for psychological and/or psychiatric problems, drug abuse and/or alcoholism, Sickle Cell Anemia, HIV status and/or AIDS.

I understand that I may revoke this consent at any time and that this consent will automatically expire in 90 days from the date signed below. This hereby releases the sender from all legal responsibility or liability for the release of information described above from my records.

Patient Signature: _____ Date: _____

Witness: _____ Relationship: _____

Clinic Employee: _____ Date Sent: _____

Arrowood
MEDICAL CENTER

9720 South Tryon Street
Charlotte, NC 28273
phone (704) 588-7362
fax (704) 588-9127

Appointments and Walk-In
Open Monday-Friday 8am-6pm,
Saturday 9am - 5pm

Occumed
AT RIVERVIEW

1393 Celanese Road
Rock Hill, SC 29732
phone (803) 327-0033
fax (803) 325-2232

Appointments and Walk-In
Open Monday-Friday 8am-8pm

Riverview
MEDICAL CENTER

1393 Celanese Road
Rock Hill, SC 29732
phone (803) 329-3103
fax (803) 327-7937

No appointment necessary
Open 24 hours!
Seven days a week