



207 Charlotte Street
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(828) 251-2700
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Medical Records Release

I, _____, do hereby consent to and authorize _____ to disclose to _____ the health, medical information and/or diagnostic tests requested below.

Reason record is to be disclosed: _____

Records Requested: 1. Dates of service _____ to _____
2. All Records
3. Other _____

Patient Social Security Number: _____ - _____ - _____ Patient DOB: _____

This information is not to be forwarded or released to another person or party without my explicit consent.

Patient Signature

Date

Parent/Legal Guardian/Authorized Representative

Date

Witness

Date

Method of delivery: _____ Fax _____ Mail _____ Release to Patient
Thank you for your help and prompt attention.