FAMILY TO FAMILY
Your Home for Whole Health Care

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ (Print patients full name)

_____ (Birth Date: Mo/Day/Year)

_____ (Street Address)

_____ (Social Security Number)

_____ (City, State, Zip)

_____ (Daytime Phone)

I AUTHORIZE (circle appropriate place)

_____ **Doctor name**_____
City, State _____
Fax: _____
Phone: _____

_____ **Family to Family**
Asheville, NC 28801
Fax: 828-251-2725
Phone: 828-251-2700

TO RELEASE MY MEDICAL RECORDS TO THE FOLLOWING PERSON OR PLACE (circle the appropriate place and fill in information, please fill out multiple forms for each place)

_____ Name Doctor/ Self _____
City, State_____
Fax: _____
Phone: _____

____ **Family to Family**
Asheville, NC 28801
Fax: 828-251-2725
Phone: 828-251-2700

PURPOSE OF DISCLOSURE (please check the appropriate reason)
Consultation _____ Transfer of Care _____
Other (describe)_____

PLEASE INCLUDE THE FOLLOWING IN INFORMATION
____ Specific Report (describe specific document) _____
____ Specific Date of Service: _____
____ Complete Record
____ Abstract (the usual & customary information that my doctor or specialist would need to continue my care or my insurance company might need to process my claim - includes test results, physician exams, procedures, diagnoses)

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization. I further understand that there may be a charge of $25 per place this information is sent to.

_____ Signature of Individual (or legal representative, specify below)

_____ Date

___Parent ___Legal Guardian ___Health Care Power of Attorney ___ Administrator
___Executer of Estate ____Next of Kin ____Beneficiary

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