CATAWBA VALLEY MEDICAL GROUP

P R I M A R Y C A R E

CVFM-Bethlehem: p-828.732.5680, f-828.732.5681
CVFM-Claremont: p-828.732.5050, f-828.732.5051
CVFM-Conover: p-828.732.7450, f-828.732.7451
CVFM-Graystone: p-828.732.5600, f-828.732.5601
CVFM-Long View: p-828.732.5650, f-828.732.5651
CVFM-Maiden: p-828.732.5000, f-828.732.5001
CVFM-Medical Arts: p-828.732.5100, f-828.732.5101
CVFM-Mountain View: p-828.732.5150, f-828.732.5151
CVFM-North Hickory: p-828.732.5350, f-828.732.5351
CVFM-Northeast Hickory: p-828.732.5550, f-828.732.5551
CVFM-Parkway: p-828.732.5780, f-828.732.5781
CVFM-South Hickory: p-828.732.5500, f-828.732.5501
CVFM-Sherrills Ford: p-828.732.5450, f-828.732.5451
CVFM-Taylorsville: p-828.732.5300, f-828.732.5301
CVFM-Viewmont: p-828.732.5800, f-828.732.5801
CVFM-West Mountain View: p-828.732.5250, f-828.732.5251
Catawba Valley Family Care-Newton: p-828.732.5180, f-828.732.5181

MEDICAL RECORD RELEASE FORM

PATIENT NAME:____
LAST FIRST MIDDLE MAIDEN

DATE OF BIRTH:______________________________ SOCIAL SECURITY #:______________________________

I HEREBY AUTHORIZE CATAWBA VALLEY MEDICAL GROUP (PLEASE CHECK ONE):

☐ TO OBTAIN MY RECORDS FROM: ____

FAX #____________________ PHONE#__________________ ADDRESS____

☐ TO RELEASE MY RECORDS TO: ____

FAX #____________________ PHONE#__________________ ADDRESS____

FOR THE PURPOSE OF (PLEASE CHECK ONE):

☐ TRANSFER OF CARE
☐ OTHER (LIST REASON) ____

MEDICAL RECORDS FROM THE FOLLOWING TIME PERIOD ARE TO BE RELEASED:

FROM____ TO____
Date Date

INFORMATION REQUESTED INCLUDES (PLEASE CHECK ALL THAT APPLY):

☐ ALL RECORDS
☐ DRUG, ALCOHOL TREATMENT RECORDS
☐ PSYCHIATRIC TREATMENT RECORDS
☐ AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus)
☐ OTHER: ____

Right to terminate or revoke authorization: This authorization shall expire (60) days from this date. You may revoke or terminate this authorization by submitting a written revocation to our practice.

Potential for re-disclosure: I understand that once the authorized organization or person receives this information, then this information may be subject to re-disclosure. It may not be possible to ensure your right to protection of the privacy of this information once our practice discloses it to another party.

Effect of refusing authorization: If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Rights of the individual: You have the right to contact and request that your information be protected from anyone that you release your health information to.

____ ____________________
Signature of Patient or Patient's Legal Representative and Relationship to the Patient Date

The information contained in this document is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any distribution or copying of this communication is strictly prohibited. If you receive this communication in error, please notify us immediately. Thank you.